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WAYS OF DEVELOPING AND UTILIZING PSYCHIATRY IN COMMUNITY HEALTH AND WELFARE PROGRAMS *

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IF psychiatry has meant anything far-reaching to medicine, it is not nearly so much through its technical contributions toward the handling of neurotic and psychotic patients as because of its insistence that the treatment of a focal problem of a person —his heart, his teeth, his wife, his job, his hereafter—is inadequate if it leaves out of account the fact that man is a complex social creature who must be studied along with his focal problem. The person is a complex of all of these focal activities, a complex of organs, all affecting one another, of which his behavior is an expression. He is one in a complex of persons, all affecting one another, in a complex of families, in a complex of generations, in a complex of environmental variables. A new medical perspective has resulted from this rediscovery of the patient, in which the doctor sees the organ disorder—perhaps a gastric ulcer—in the setting of a man who is trying, against certain odds here and there in his body or in his environment, to live a satisfactory life. The doctor is more apt to evaluate his professional services to that stomach—that is, his effort to cure it of its ulcer—as good or poor depending upon how the result affects the living of his patient.

I have emphasized this concept because it obligates me to raise certain questions whenever a proposal is made to offer some new service to people—particularly when the service

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under consideration is as likely to change human lives as is psychiatric service. I am obliged to look at the implications of this new service below the surface or beyond the meeting of the visible need. I must first of all see how that psychiatric service fits into a well-thought-out concept of community organization, taking into account more than that which is just beyond the tip of my nose. I must ask myself: Will the organization of *this* service, according to *this* pattern, fit comfortably into the complex of *this* community's agencies, especially if they have been set up on a sound internal structure? Will the psychiatric agency be *comfortable* enough to do its job with economy, with a minimum of housekeeping, apple-polishing, and compromises? Will it be able to do *effective* psychiatric work? Will it be *sufficient* in amount for the community's needs? Economy and comfort, effectiveness and sufficiency may be impaired by inadequacies of the community outside of the psychiatric agency. The schools, courts, and other agencies may not be doing as much as they could within their own spheres. If so, this may be accepted as a problem to be met on its own ground rather than through the introduction of a new service. The main thing is that a new plan should not follow erroneous patterns of the past. Consequently, I want to dwell for a bit on some points about community function that I think are important to the people who live in a community.

To begin with, a clear distinction should be drawn between a community and a crowd. A community is a structure whose capacity for achievement is greater than the sum of that of the individuals who compose it. In a democracy, it is an implement of those individuals, their means of securing advantages in life that are beyond their power as individuals or as families. A crowd is the raw material of a community, unorganized, not pointed up in its goals. The frontier camp for a few days is nothing but a crowd; soon it becomes an embryonic community; and as time goes on, it develops the community functions that are found in established municipalities.

It is no accident that both in new and in older communities, in those that evolved spontaneously as well as in those that were planned from the start, we find the same services. The functions of a community are the counterpart of the needs of man, and in so far as those needs are universal, communi-

ties are similar, providing service for the sick and for those threatened with sickness, for the hungry, the thirsty, the ignorant, and the cold, for those in danger of attack, for those wishing to travel, for those wanting to trade, for those needing justice, and for those wanting communion.

These are needs of men, but these needs are not so clear-cut in real life. Jimmy plays hooky. This is a human-life episode. To Jimmy it is an impulse-satisfied, a unit. Behind it may be hunger, inadequate clothes, bad tonsils, improper placement in school, nagging parents, compulsory-education laws, limited intelligence, and crowded living, and because of this multiplicity of factors, Jimmy may become the "property" of first this and then that community agency, each of which is dealing with a part or a focus of Jimmy, but none with Jimmy. To him his episode was a unitary occurrence; all these various factors were integrated to the point where they became truancy. Never can the truancy be dealt with adequately by any piecemeal process; Jimmy must be dealt with. The crucial point is that unless the services offered by a community are brought together and offered as a true counterpart of needs as they arise from people, and in such a way that the beneficiary gets a feeling of help from the community rather than from three or four separate agencies, the community is only partly deserving of the name. To-day we are in a stage of cultural evolution in which community functions are progressing, but they still fall far short of being an integrated service that respects the oneness of the people served. We are progressing toward that ideal because, as technical fields expand, particularly in preventive directions, they encounter the expanding periphery of other technical fields and, after border skirmishes, come to an understanding. Most of our technical fields developed as a direct, circumscribed response to an emergency—crime, poverty, insanity, pestilence, and the like. Preventive effort has caused them to spread more widely and more deeply to a point where the common ground beneath the technical efforts is reached. This trend should move us closer and closer to the goal of an integrated community service tuned to the needs of the people served.

But there are certain counter tendencies that may delay this progress. As a field of service sees its scope widen and

becomes aware of a need for broader technical facilities, it has two courses open to it. On the one hand, it may look at the expansion in a proprietary way, as a function growing out of its efforts and therefore its own, to be carried out by it alone. We then experience a departmental expansion. The department may gird itself with publicity experts, laboratory experts, clinical experts, research experts, and multitudes of consultants, all on its own pay roll, while specific agencies for such services exist and other departments expand in the same way.

In most instances, it is not able to use the full time of its expert consultants, so, if lucky, it gets a part-time expert, or else one person expert in two or more fields, a "half-baked" expert. The realization of this trend in its final form would be the creation within a department of community service of a miniature community, providing all the services needed by the person who appears at its door with its particular "ticket of admission"—education, health, protection, food, justice, as the case may be. This comes about because, as it studies its clients, beginning with the particular range of complaints that brought them to seek its help, it is led inevitably to the whole of human living and tries to serve all the needs of its clients. It tends toward a proprietary attitude toward all the services that relate to its problems. This is no fantastic dream. Organizations such as I have described are to be found in every city, and the larger the city and the more departmentalized, the more certain they are to be found. The unfortunate side of this is that *no agency* can fully realize such a policy, and so the persons whom they are trying to serve suffer. Also, this policy negates the necessity for functional collaboration between agencies, a necessity that comes about through the impracticability of the all-inclusive effort just described, and through the fact that, willy-nilly, people do get into the hands of several agencies in a community.

Contrasted with departmental or agency expansion is the policy of interdepartmental or interagency collaboration. Under a pattern of interdepartmental collaboration, a breadth of service commensurate with and corresponding to the breadth of human needs is achieved for the clients of one department or agency through joint action with another. The professional effort that in the first case is expended in conflict

between agencies is here expended in making arrangements for collaboration, defining procedures, and beating paths between agencies. The energy expended in expansion goes toward increasing the resources that are needed for collaboration, refinement, and research in the narrower scope. The proprietary, bureaucratic, and vested interest gives way to interest and satisfaction in a job better done by collaboration. Such a pattern of service promotes the approach toward an ideal community.

These considerations of the community are of importance to our subject, "Ways of Developing and Utilizing Psychiatry in Community Health and Social Welfare Programs," because they face us immediately with this question: Shall every agency of the community that encounters severe psychopathological problems engage its own psychiatrist, or is need for psychiatric service great enough, and is the service distinctive enough technically, to warrant an agency that can collaborate with other agencies as needed? The principle involved is the same as in the question: Should the health department or the schools have the responsibility for health services to children? We can find schools that provide better service than some health departments, and we therefore need to be careful lest we be misled and diverted from attention to a broader principle of the community and beguiled into departmental expansion.

The effective plan for providing psychiatric service is through *administrative centralization* with *functional decentralization*. This means that while we may set up a strong central, technically qualified psychiatric agency, the service itself must be dispensed in keeping with the needs of people, at headquarters or away from headquarters. The agency must be fully capable of functional decentralization wherever or whenever the needs of people require it. It must so merge into the work of the health department with this patient, of the welfare agency with that client, and of the school with this pupil, that the patient, client, or pupil will have the feeling of being given one service, rather than psychiatry to-day, lessons to-morrow, and relief some other time.

The development of psychiatry in the past gives full support to the value of administrative centralization, as evidenced by the technical concentration in the state hospital as

an outgrowth of the county almshouse. Unfortunately the state hospital has not yet achieved functional decentralization, but it is moving in that direction. It must not be forgotten that for most communities the psychiatric department or division of labor is not situated and controlled locally like health, or quasi-locally like education, but regionally. New Britain's department of psychiatry is at Middletown, but that makes it no less important to New Britain and its health department and no less a subject for concern, interest, lobbying, criticism, or praise. For most of the smaller communities of a state, there is no prospect of a department of psychiatry any nearer home. There may be in New Britain because of its size.

We are confronted, then, with this concrete question: Where are the people of a state who are not patients in mental hospitals going to get psychiatric help? If you wish, you can ask, "Where are teachers, social workers, health officers, nurses, and others going to get such service?" provided you see this primarily as a service to people and secondarily as a help to a profession.

In the larger communities of the state, there are prospects of developing local psychiatric services. This form of provision has certain advantages. The staff is rooted in the community and therefore has a better understanding of it; it has continuity and a close view of its work; it appreciates local attitudes, standards, occupational resources, and potential co-workers. The local clinic is more accessible. Careful planning by the state can, however, decentralize function well enough to capture most of these values. That I shall discuss later. On the principle of administrative centralization of community function along technical divisions of labor, it is important that the local psychiatric service of a community —aside from private medical practice—should be concentrated. This gives it perspective, since the same staff serves all community agencies; gives it strength as contrasted with separate arrangements for each agency; gives it economy through the elimination of administrative duplication and wasteful repetition of service; and at the same time the functional decentralization whereby the psychiatrist works in the quarters of other agencies offers all the advantages of having a psychiatrist close at hand on the staff of one's own agency.

Such service requires a minimum of housekeeping; it is comfortable, efficient, and as sufficient as the resources of the community permit. The psychiatric agency may be administratively independent, with its own board, or it may be a department of another, perhaps a health, agency. Satisfactory services have been developed under several different auspices, but it is essential that the administrative connection be not permitted to restrict the opportunity to give equal service for equal needs throughout the community. To allow of functional decentralization wherever necessary is crucial to the protection of the patient. The psychiatric service that is centered in a health department should not be thought of as belonging more to other divisions of the health department than to the court or the welfare agencies. It should be constantly kept in mind that the only justification for such a facility is the needs of people and that these needs are the prime determinant of policies.

Provision may be made for one or more of the psychiatric staff to go to the headquarters of this or that other agency to carry on their work. In this way all the advantages of psychiatric service within the agency's own staff can be achieved without the disadvantages of the weakness that comes from a scattered psychiatric service. In this way it is possible to render several types of service. There may be treatment services of various sorts. There may be a diagnostic service that either leads to better planning within the original agency or to continued psychiatric service for those who need it. There may be consultation with other professional workers or agencies about patients, without direct contact with the patients, but depending on interpretation of their records. This type of service must be properly safeguarded, but it has both educational value to the worker and service value to the patient. There may be consultation about the psychiatric implications of general policies and procedures in an institution or agency, the basis for this being certain general mental-hygiene principles or acquaintance with a series of cases that have been subjected to such policies and procedures.

These are important considerations in establishing local services in the larger communities, although it is recognized that they are more difficult to attain where the service is

given from a distance and where local agencies are more limited.

It seems very likely that smaller communities will as a rule have to accept the fact that their local psychiatric agency is the decentralized service of an agency covering a larger territory. Such larger agencies include the state hospitals or perhaps the state department of health. Neither of these agencies has been developed to a point where any great degree of coverage is achieved, but the potentialities exist. The development of the mental hospital as an adequate community resource for other than intramural service is one of our most pressing needs.

I should like to dwell for a moment on the reasons why these potential resources have not developed further. What I have to say is not peculiar to any state—in fact, it applies to every state. Why have our psychiatric hospitals not developed a greater degree of community responsibility? What do we have to take into account, if they are to function in this way? The answer is to be found in several factors—the isolation of the hospital, its historical background, the public attitude of fear toward it, its limited budget, its use for political purposes, its gravitation to a pattern of administration that is determined too much by considerations of good housekeeping at the expense of the fullest service to patients. Because of these factors, a hospital does not know the community from which a patient comes sufficiently to understand him as well as it might and to plan for his discharge. Legislatures are impressed by good housekeeping and the people are gratified to have their insane out of sight, out of mind, the supposed danger removed. They are complacent about politics.

The geographical isolation of the hospital is probably inescapable, owing to its need for a large acreage. This means that an extra effort must be made to overcome functional isolation. Many hospitals have done admirably on this score. They have made special efforts to be an important part of their communities socially and otherwise. They have added professional staffs whose function it is to take the home and other usual elements of the patient's life into account in his study, treatment, and rehabilitation. The community can do much to encourage this effort. This service to its existing

clientele is a hospital's first step toward meeting the psychiatric needs of its communities, for it demands a close relationship to community agencies.

Even if the hospital were not geographically isolated, it would tend easily to become functionally isolated because of the public attitude toward it, and both hospital and community must work hard to overcome this. There was a time when this creepy feeling toward the mental hospital was primarily founded on fear—fear of the crazy man, the fear that brought about the same judicial procedures that were used in cases of crime. To-day we have less of this, but we have more of the element of guilt. It is hard to commit to a hospital as irresponsible a parent, or a brother, or a wife with whom one has lived and who is a part of one's life. The dignity of the personality remains in the face of the worst shattering, and its suppression, even though necessary, arouses a sense of guilt on the part of those who have become involved in the patient's private life and the social conflicts that have resulted from the disorder. If the hospital is some distance away, one can forget this guilt to a degree, and such remoteness is at times comfortable. This attitude blocks the hospital's opportunity to realize its fullest value to the community when it tries to do so. Argument and demonstration of its value are only partially successful. It takes more than intellectual understanding to change feelings. Careful work with the families by other community agencies is required to overcome this fear and guilt.

Inadequate financial support and tolerance of political interference are by-products of the public attitude. The hospital is, of course, unable to speak effectively for itself, since to those of bureaucratic ideology it is an interested party. Its remoteness prevents the public from fully appreciating the advances that have been made in hospital services, and so the old attitude hangs on. A change in this depends more on the community agencies that see the families and that might get help from a hospital than on the hospital's own efforts. These community agencies have a large stake in the development of the community services of the mental hospital. As these agencies see their efforts frustrated and critically analyze their own problems, they reach a point where the psychiatric factor is often recognized as primary, where this

factor, under the cloak of prejudice, is large enough to spoil a good public-health, welfare, or court effort. At this point these agencies have a large stake in the extension of the hospital. It is largely their task, if they want psychiatric service, to prepare the public to accept it, if not to demand it.

Who should take the lead in drawing this psychiatric resource into greater usefulness? Usually one agency starts the ball rolling in this direction, and usually it is an agency that has moved along somewhat faster than others, but it is not always the same type of agency. Here it will be a court, there a visiting-nurse association, and in some other place, a school or a social agency. Wherever the demand arises, it is important that it be viewed as a community need and not as an opportunity for agency expansion. The validity of this can be understood if one considers where the pathology of psychiatric problems is to be found. From case to case, emphasis may shift from physiological or organic disorder to psychological factors, or to social and cultural peculiarities. The presenting symptoms are similarly diverse and do not always show where the causative factors are. A problem may, for example, be culturally determined and yet appear as a neurotic heart complaint. Because psychiatric problems are so variable it is easy to understand why any one agency may feel that it has a very large stake in psychiatric service and, by extending this idea, that it has more of a stake, and therefore should have more to say about this service, than other agencies. One pediatrist may see premature infants die and sense no psychiatric implications in the fact. Another may analyze this same problem, and find that, although the babies are in good condition upon their discharge from the hospital, immediately thereafter they start downhill because his directions are not followed. He tries to discover why they are not followed, and is led immediately into fears, resistances, or stupidity on the part of the mother. To him psychiatry may be an essential aid in dealing with certain cases of prematurity. The prenatal clinic that specializes only in urines, blood pressures, and Wassermanns sees little need for psychiatric service, but the imaginative clinician who relates attitudes that he discovers in the prenatal period to the life problems of his patient sees a great

public-health opportunity both for parent and for child in dealing with these psychological factors.

I would not want to be understood as saying that all such matters require a psychiatrist; most of them are in the realm of psychiatry that is part of all medical, judicial, and welfare practice, or, if you prefer, the art of these activities. Much of this art existed in common-sense form before there was such a thing as psychiatry. Some of it has been enriched by psychiatric studies. Attention to these problems brings to light needs for psychiatric service not otherwise recognized. This type of consultation and critical analysis in turn strengthens and enriches the art. If I had to and could make a choice, I should feel that the non-specialized art is of more far-reaching importance, but I doubt if this art can grow without the more specialized service to enrich and support it on the one hand, and on the other hand, to keep it from running wild.

This means that every community agent whose work influences people deeply must be both a specialist and a general practitioner. Up to a certain point, he must be prepared to help people as they come for help. This means that every doctor, nurse, health official, social worker, teacher, and court official must have a common minimum of the knowledge of all these fields. The social worker should know enough of health practices to be able to see the need for health services, at least better than the man in the street, and to give the right health values to whatever he does. The teacher should know enough of social-service practice to prepare a prospective client to receive help from a social-service agency when necessary. Each agent should be able to steer those whom he is helping to the right specialist, both to avoid squandering of community resources by blindly referring cases without clear indications for such reference and to avoid confusing the client by an unnecessary multiplicity of consultants. This means that he has a personal stake in the quality of the other community agencies to whom he refers people. His reputation and consequently his usefulness are jeopardized or enhanced when the person he refers gets poor or good service. He has, therefore, a right for his own sake and an obligation for the sake of the people of his community to be articulate about the work of his co-agents, being careful to

be just as attentive to their strengths as to their weaknesses. We have grown beyond the point in the evolution of our community functions where one agency can say to another, "You attend to your job and I'll take care of mine." One must at the same time be able to distinguish between the good and the poor job of a collaborator and yet beware of assuming to be an authority on the technical details of another field.

We have heard much in recent years about the avoidance of overlap between these various community agents. I think it will be evident to any one who is familiar with the problems of people that sharper divisions of function cannot exist between the agencies serving man than exist in man himself. This reality demands that a definite overlap in the functions of agencies is to be hoped for to insure collaboration. The important point is that co-agencies should not allow this overlap to work to man's disadvantage.

In conclusion, I should point out that while I have apparently deviated from my subject of psychiatry in talking a great deal about the community, these principles are so fundamental to the effectiveness and spirit of psychiatric service that they are really very pertinent. If they are adhered to, the specific psychiatric organization is not so much of a problem. It is either a question of organizing a local service with adequate personnel, or of securing from some larger political subdivision a decentralized service, enhanced as much as possible by a supporting and collaborating local organization. This is the essence of *developing* such service.

Utilizing such service is likewise a corollary of these principles. There are mentally ill people, psychotic or neurotic, who appear in every agency and who need psychiatric treatment more than anything else. For this primary responsibility, a psychiatric agency is necessary. There are also mentally ill people for whom treatment holds little prospect of success or who have more emergent problems in some other field. For these the psychiatric agency acts as an assistant or consultant to another agency, health, welfare, or education, which carries the leading responsibility. Then there are persons about whose behavior the non-psychiatric agency has some doubt, or whose cases present possible psychiatric implications. The psychiatric agency here acts as a consultant to the worker, using the record instead of dealing with the

patient directly unless indications for direct service appear. There are new workers and even some of the older workers in the co-agencies who have not that minimum of psychiatric knowledge that is necessary for the generalized ability that each worker should have. For these the psychiatric agency is an educational instrument, as far as possible, of course, through its clinical cases.

And finally there are larger influences bearing on the mental health of the public directly or indirectly through school practices, dispensary practices, court practices, recreational facilities, industrial conditions, and the like. These influences come to light through the patients of the psychiatric service who have broken under them. It is the task of the psychiatric clinic to reveal and to weigh these threats to the mental health of the public. An aggressive public-health program can use these findings for continuous progress in making the community a safer and a better place to live in.

THE CONTRIBUTIONS OF RELIGION TO MENTAL HEALTH *

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WE are aware that the idea of health has in recent years undergone a transformation that amounts almost to a revolution. Although we shall be mainly interested in discussing the contributions that religion can and does make to health, it may be helpful to review the main factors in our present-day notion of health.

The word "health" descends from the Old English "hælth," meaning wholeness or soundness. But even further back we find the idea of health as a unity of personality noted by such men as Plato. Socrates is said to have come back from the Thracian wars praising the barbarians for looking on health as a concern both of mind and of body.

Obviously there are important reasons why this Greek idea of the essential oneness of mind, body, and spirit was not widely held until quite recently. I do not intend to retrace the history of medicine or philosophy in amateurish fashion; the essential facts are well known. But it may be pointed out that modern scientific medicine arose at a time when philosophy and theology were in general separated from science—at a time when science, in the process of emancipating itself, felt that it had to throw over "silly metaphysical ideas" about unity and get down to brass tacks. We can hardly blame nineteenth-century scientific workers for their bias against mental and spiritual factors. The only alternative most of them saw was a vague kind of mystical idealism which did little to find the causes of ill health.

But the clinical approach has brought medicine out of its materialism. So long as medicine—or let us speak more broadly of health work, which would include most social work, in one sense—felt that it had to depend on a materialistic

* Presented at the Pennsylvania Conference on Social Work, Wilkes-Barre, Pennsylvania, January 31, 1940.

philosophy, so long was health thought of in terms merely of absence of germs and organic pathology. But as health work became more clinical—that is, as it depended more on what it could learn from patients—this single-track view became untenable.

It is by clinical investigation (call it case-work if you are a social worker) that the older ideas are being slowly overcome. The essential point may be made clear by a simple and effective quotation from Dr. G. Canby Robinson:

> "Man is a unity of mind and body, and medicine must consider this unity. Physiology, chemistry, and biology cannot alone or together explain all the intricacies of illness. The disturbances of mind and body cannot be dealt with separately; they form two phases of a single problem. To insure health for the individual, the mind as well as the body must carry out its natural functions freely and efficiently. Fortunately there is evidence of a widening acceptance of this fact."[1]

Health is, therefore, no longer exclusively the concern of the physician, or even of medicine in the broader sense of the term which includes public health, nursing, occupational therapy, and some social work. If our point of view is correct, it will have equal relevance for the teacher, the industrialist, and the clergyman or rabbi. For the teacher is not interested merely in the intellect and the minister merely in the soul, any more than the physician can be interested only in the body or the social worker only in the environment. Health is a far more universal concern than we believed even a few years ago. Mental hygiene, both as a content and as a movement, has, of course, been the most significant influence in bringing this about.

II

Religion itself can and does make a contribution to health that is even now greater than we realize and that can be made more significant if we understand and utilize the principles involved.

But not all religion makes a positive contribution to health. Religion may be healthy or unhealthy (pathogenic), depending upon its quality. By quality I do not necessarily mean Christianity as against some other religion, or Presbyterian-

[1] *The Patient as a Person*, by G. Canby Robinson, M.D. New York: The Commonwealth Fund, 1939. p. 10.

ism as against some other denomination. I am thinking of the individual's interpretation of, reverence for, and use of what the great religions teach. I know one man in his early forties who, while his religious ideas as such seem sound, in practice uses his religion mainly to get his children to do what he wants them to do. I know, too, an elderly woman who has used religion for forty years to keep her daughter at home dancing attendance upon her. And I know a man who boasted with considerable vehemence that he did not believe in God. After finding out what kind of God he did not believe in, I had to confess that I could not think of believing in such a childish God either.

Perhaps we should be a bit more systematic in discussing these factors upon which the healthiness or unhealthiness of an individual's interpretation of religion depends. A healthy religion—and remember that we are speaking of health as health of the whole personality—must first be related to the whole personality. It cannot deal only with the soul and neglect the mind and the body. It cannot, for example, feel guilt about dancing while remaining indifferent in the face of economic exploitation.

A healthy religion, furthermore, must grow up intellectually and emotionally along with the rest of the personality. Of course it is silly to "disbelieve" in a childish conception of God, as silly as it would be to assert one's disbelief in what the idea "earth" meant to one as a child—or, to put it in the emotional field, to assert one's disbelief in the existence of one's father because one's early ideas of the father's omnipotence no longer exist. Religious ideas and religious feelings must grow up, too.

A religion that makes for health must also be non-substitutive and non-compulsive. A religion, for example, that replaces the need for earthly friends by supplying heavenly friends may be healthier for the individual than no religion at all, but a truly healthy person's religion is something added rather than something substituted.

The compulsive character of certain individual interpretations of religion may be illustrated by some of the attitudes that are often praised incorrectly as fine religious outlooks. One of these is submissiveness, which is essentially a strategy of trying to get what we want by making the other fellow

sorry for us. Mental hygiene has told us enough about the dangers of the model child to make this clear. Power-getting through the institutions of religion is also often mistaken for a sound religious outlook. We all know the church worker who expresses his craving to lead or to boss only in church activities because there he will not meet with the open rejection he might find elsewhere. More subtle than either of these compulsive ways in which religion may be used is trying to coerce others into loving us. Many a mother who uses the familiar refrain, "Look how I've slaved for you," to her children adds privately to herself that the children must be little devils to ignore the religious command to honor their parents. The many techniques for coercing love when one is unable to get it by the proper means, which is by giving it, may all be tied up with religion. Since coerced affection is no affection at all, these compulsive trends make for anything but health.

In the fourth place, a religion that makes for health must be outgoing; it must have a social as well as a divine object. The "emotional atheists" I know are people who feel so defensive about themselves, who have so little real regard for what they believe themselves to be, that they could not possibly have regard or reverence for anything outside themselves. I am not implying that only extraverts can have a healthy religion. But a healthy religion implies that one must be free enough, feel safe enough, within one's self, to warrant pushing out one's spiritual tentacles toward objects of affection and reverence.

We now have some idea at least of what we mean by saying that religion is healthy or unhealthy depending upon its quality—a quality not so much of ideas as of emotional interpretations. This should in no sense imply that religious ideas are unimportant, or that one idea is as good as another. What it does attempt to do is to get at some of those processes by which a person may warp perfectly good religious ideas to meet neurotic emotional needs, and then either blame religion for his failure or use it to justify the failure. After all, it is logical that one who warps other aspects of experience to meet neurotic needs will do the same about religion. This is in no sense to condemn the person with inadequate religious interpretations; for if we look deeply enough, we

can always find sufficient unfortunate emotional factors in his background to account for these.

III

If we suppose that a person has a healthy emotional interpretation of religion, in what ways specifically does his religious life support and enhance the health of his whole personality? Though it is valuable to put our question in this way, we should not forget that none of us have "perfect" interpretations of religion. What we do is to share certain insights into the nature of reality and our relationship to it. We are speaking, then, as much of religious outlooks and practices that may be used for improving health as of simple examination of the influence of fine religious insights that are already present.

1. Religion alone can help us to integrate our lives around the reality in the universe which is both rational and meaningful—the only worshipful reality. We have already hinted that a lack of reverence or regard for that which is outside ourselves is a kind of blocking of natural trends toward socialization, and that it is caused by a feeling of lack of psychological safety and security within ourselves, however unconscious this feeling may be. If a person is tied up in knots inside himself, will power will not get him out. But if religion can give him a vision of something in the universe that he can actually trust, he is on the road to finding himself. In such a person's background we find usually that he has not been able to trust—that his mother, for example, sometimes slapped him and sometimes gave him a stick of candy when he disobeyed instead of being consistent about his emotional education. How can such a person be other than tied up in knots? Of course he may take religion and tie it up inside himself along with everything else. But if he gets any vision of that meaningful reality which does protect and bring safety and security, it may help him so that he will look for the evidences of security and affection that exist all about him and even in himself.

2. In the second place, religion may help to get a person away from egocentricity, infantilism, and the avoidance of responsibility. We know to-day that most stages in the growth of the emotional life are accompanied by more pain

than we later remember. Once the transition is made—for example, from the gang period to adolescence—the rewards of growth and new responsibilities normally outweigh the pains. But in some persons the pains are so great as to retard the progress, and in none of us is the process entirely smooth or complete. And it is so easy to relapse into infantilism or avoidance of responsibility about some things that are especially important. Here religion may enter. Suppose that one's particular infantilism is to ridicule the prevalence of great social needs, to feel at least that paying attention to them is none of one's own business. And suppose that such a person somehow gets a vision that the brotherhood of man is the other side of the coin of the fatherhood of God? His social conscience can no longer be so dull or so dulled.

3. If I had a text, it would be this story from Luke (11:24–26): "When a foul spirit goes out of a man, it roams through deserts in search of rest, and when it finds none, it says, 'I will go back to my house that I left.' And it goes and finds it unoccupied, cleaned, and in order. Then it goes and gets seven other spirits more wicked than itself, and they go in and live there, and in the end the man is worse off than he was before." The search for health cannot be merely negative. Mental hygiene cannot be merely a process of chasing out evil spirits. For if the devils are chased out and nothing constructive takes their place, the person may indeed be worse off than before. Never take away a man's crutch unless you can say, "Take up thy bed and walk." And religion can say this, metaphorically speaking. Healthy religion ought to furnish the constructive occupant of the house. The evil spirits must be driven out, to use the ancient language, but that is only half the story. Health in our usage is not merely negative—it is also positive; but it cannot be truly positive unless the perspective and the insights of religion are a part of it.

There are two ways of reaching a goal. The first is keeping one's eyes fixed on the goal and ignoring the obstacles. This should be known as the cracked-shin method. The other is keeping one's eyes on the obstacles and failing to look at the goal. We may call this the wander-in-circles method. Neither is adequate in itself. The great contribution of mental hygiene to religion is the pointing out of the real

nature of the obstacles; the great contribution of religion to mental hygiene is the vision of the goal.

4. Healthy religion makes a person less dependent upon mere cultural standards, upon keeping up unconsciously with the Joneses. We live in a culture in which a man's worth is too often judged by his skill in competition, and especially economic competition. The spiritual danger arises at the point where a man has no other standard of judgment of his own worth than that which this cultural pattern, as one example, can give him. We know of the suicides that followed the beginnings of the depression in 1929. Though there were individual factors involved, we could see in the lives of such persons the confusion of their success in competition with their very selves. They had no concept of themselves except that which they accepted from their culture; hence they had no resources when the crisis came. I am not implying that personal worth should be independent of what one does, but that one should have standards in reaching an estimate of one's personal worth which go deeper than that of keeping up with the Joneses. If religion gives anything at all, it is this. What but this can give the magnificent courage to our brother religionists who are being persecuted in many lands? This is what we mean by the religious statement that every man is a child of God. There is something in the nature of the universe that in itself gives life meaning and value. We call recognition of this freedom, but it is not merely freedom of the will. We would do better to call it freedom of the whole personality.

5. We know, too, that religion may actually have a marked influence upon the processes of healing. With mental and spiritual symptoms this scarcely needs proof. But there is also some evidence, though certainly fragmentary, that religion has an influence upon bodily symptoms and processes. This is an especially complex question, and one that of course can only be touched on here. But let me give an illustration. I know an elderly man who was brought up on a spiritual diet of that brand of theology which emphasizes the power, but not the love, of God. In his twenties he was stricken with arthritis so badly that a wheel chair and crutches were needed for some years. He believed that God was punishing him. Through a process too long to describe, he attained insight

into God as love as well as God as power and realized that his illness was not a punishment of God. The influence of this spiritual change upon his mental and physical condition was very great; within a few months his crutches were discarded.

One may well raise the question whether organic factors were really involved in this case, and I do not know the answer. The studies made by Alexis Carrel, Smiley Blanton, and others of sudden cures at the Lourdes shrine, though they are incomplete, nevertheless suggest that mental and spiritual influences may have a marked effect upon the healing processes, including those which we view as bodily. But much more important than sudden cures is the general principle. Few surgeons question that a patient's faith, or will to live, has a real influence upon his chances for recovery, even though this has never been adequately studied. It is even harder to prove that faith in God is better than faith in a rabbit's foot. But we believe that faith in God is a picture of the real nature of the universe, while that in the rabbit's foot is not; therefore faith in God will stand up. But the importance of faith and confidence as emotional attitudes in the healing process cannot be disputed.

6. We have, most of us, only begun to learn the importance of relaxation. It is true that this has been cultivated by the Eastern rather than the Western religions; but all healthy religion has some comprehension of it. By relaxation we mean something different from a physical flop into a cushy armchair. We mean the ability to go to bed at night, relax our muscles, forget the cares of the day and the morrow, and go to sleep. We mean the absence of an anxiety that drives the whole personality to continuous physical and psychological tension. We mean the ability to alternate work and relaxation in such a way as both to use and to safeguard the muscles of the mind and spirit as well as of the body. I admire those who can relax starting solely from a physical basis, those who can consciously relax muscle after muscle. Perhaps I should envy them more than I do. But the process seems too much like counting calories with every bite of spinach. Religion ought to teach us relaxation, of body and mind as well as of spirit; for I have never been able to see how the spirit could relax—*i.e.*, be receptive—if the body and mind were in a state of tension.

Here lies especially the importance of private meditation and prayer. Of course this cannot be mechanical. One cannot pray merely with the idea of seeking relaxation; one must have faith emotionally in God before one can truly pray (or perhaps we should say that one has such faith only as one prays). But if prayer does mean anything in an individual's life, it should mean that kind of calmness for which our word to-day is relaxation. Professor Whitehead speaks of religion as what man does with his solitariness. Professor Hocking refers to the alternation of work and worship. Dr. Richard C. Cabot wrote a book about what he considered the four essentials of life, all of which are necessary to a healthy personality, and to all of which religion makes a contribution. He spoke simply of work, play, love, and worship.

7. Worship is indeed a religious method that helps to develop healthy persons, though this is of course not the only aim of worship. Worship ought to and does mean many things; but strong among them is the sense that an individual thereby becomes one of a community on the level of aspiration. He bows before that which he reverences, not so much to honor it as because it is natural to do so, and he thereby gets a sense of "communion" with all mankind. All high religions believe that this community is not merely artificial or merely sociological, but that it goes deep into the nature of reality. Worship is, then, a discovery in some measure of the reality of that community. It makes a great difference what one worships. We know now why the early Christians could not worship the symbols of the Roman empire. For only in religions of the quality of Christianity and Judaism do we find a God who is truly worshipful. Worship itself is a natural activity of man, one of the motivating forces toward which is the desire for fellowship and communion; but it makes a great difference what one worships. For religion cannot be satisfied with reverence of that which is not worshipful, and cannot be interested merely in an integration of personality around ideals that are temporarily successful and efficient but that in the long run are destructive. The integration that brings real health must in the long run be one that does correspond to the nature of reality.

8. Still another contribution that religion can make to health is in developing what has been called "tension

capacity." Children want what they want when they want it. As adults we have to learn that the fulfilment of some needs or wishes must be postponed or even renounced. Thus we must develop some capacity for tension—that is, we must learn to live in situations that would ordinarily produce tension without being tense. This is an inner achievement. No one else can do it for us. This emphasis on self-discipline rather than discipline from outside is an essential part of all healthy religion. Such religion can help us attain it.

9. Finally, religion appreciates and helps us to face what we might call the irreducible mystery of life. Fortunately life is not all a mystery; and religion performs a poor service to health if it tries, as has often been done, to create a mystery where none exists, or to seek allegiance by claiming a special hold on mystery. But when all that is said, much of life and experience is still a mystery. One may ignore or deny the mystery, which is blind. Or one may think only of the day when it may be past, which is incurably romantic. Or one may work as the scientist does to make the mystery intelligible at specific points, which is praiseworthy, of course, so far as it goes. But some mystery still remains. Religion first of all faces this mystery as such. At its best, the mystery itself is never reverenced. We do not worship God because we have no idea of what He is. But the mystery is there.

In the ordinary experiences of life we know that problems must be faced as problems, not evaded or ignored. If one is to have health of spirit as well as of body and mind, one must apply the same principle in this cosmic realm. Emerson said of the great historian, Gibbon, "That man Gibbon had no shrine." A man with no consciousness of the mystery within his existence is ignoring or evading a problem. The proper attitude is of course not to magnify the mystery or to worship it, but simply to face it as such.

IV

How does all of this relate to the mental-hygienist or the social worker? Obviously it means first that he is neglecting a great therapeutic force if he does not consider religion. But of course his question is: "*How* can I use it? What you have said may be true, but I cannot do it myself and the ministers I know either do not know how to help an individual

develop his own brand of religious resources or else are too busy to give much time." The first answer to this is: Physician, heal thyself. We clergy have been told so often that we ought to get mentally healthy that it is about time we turned the tables and suggested that social workers and physicians get religious. They want us to get the right kind of mental health; we want them to get the right kind of religion. We all know well that a mental-hygiene worker whose mental health is poor will probably have a pathogenic effect upon his clients. If his mental health is good, he will have to call in a specialist on fewer occasions. To some extent the same ought to be true of religion.

Mental hygiene has a content, but a worker does not dump the whole content before every patient or insist that the patient take a pre-formed solution to the problem. Religion too has a content, but we should not dump it all upon every parishioner every moment, nor say that precisely the same form must be believed or followed by every one. A mental-hygiene worker who is religious in the best sense will help to communicate religion in the best sense, just as he does mental health, even though the specific form of the client's religion may be different from the worker's.

Of course clergymen should be called on as specialists, and too often we are not trained in the case or clinical method of approach. But to expect the minister to be the only one who is in any sense religious, or who has any responsibility for religion, is as bad as to believe that interpersonal relationships should be confined to mental-hygienists or social workers.

Social workers and psychiatrists have long pointed out, and rightly, that a clergyman is inevitably an influence on the mental health of his parish, whether for good or ill. He has no choice; all he can do is to try to go in one way or to slide into the other. It is high time that he recognized this. But may it not be said with equal truth that the mental-hygienist or the social worker is inevitably an influence for religion, either for good or ill?

Mental-hygiene workers and the clergy need to get together more, to understand each other better. Each of us has our professional neuroses, and it would help us clergy, especially, if mental hygiene would help us to get a little insight into

them. More important, there are human needs for health and religion that will go unmet unless we do understand each other so well that we shall coöperate more frequently and more effectively. I am convinced that in the last few years tremendous steps have been taken in this direction. But we need to push forward through the professional contacts of every day, where real human need is at stake and where all of us feel—clergy and mental-hygienists alike—that we have some measure of responsibility for the particular children of God in our own communities and parishes.

MENTAL HYGIENE AND RELIGION *

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THE mental-hygiene movement as we know it is scarcely over a quarter of a century old, yet the history of man and his institutions leads us inevitably to the conclusion that achieving a modicum of control over individual and group behavior has always been one of the chief preoccupations of society. Conflict began when it became necessary for the individual to surrender some of his privileges and personal satisfactions for the welfare of others. Whether conformation to a group pattern was to be achieved by means of religion, law, or tradition is at this point immaterial. It is sufficient that we regard conflict as an inevitable process in human adaptation with many variations in degree and severity.

We are now in a period of cultural, religious, and political change that is completely unprecedented. Will the individual be held rigidly to group behavior patterns without great pressure? Totalitarian states have succeeded in uniting their populations by the use of fear and force. Will the individual become less and less significant in our political and cultural pattern as it becomes necessary for him to band with his fellows in order to deal effectively with problems that involve not only his industrial, but also his political and family life?

Poor mental health is as old as man's conflict with his world, and the more complicated our system of living becomes, the more difficulties man encounters in effecting a harmonious adjustment with his environment. In spite of all the success that has rewarded civilized man in his effort to achieve control over his environment, he has had little success in achieving control over himself and his own impulses. One needs only to consider in passing the enormity of the problems of crime, delinquency, and mental disorder to see that this is true.

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Dr. William A. White has stated: "The mind that surveys the world knows more of the world than of itself." Certainly the mind of man, unquestionably the most powerful force in the world, is potentially as capable of solving the problems of human behavior as it is of finding answers in the fields of science and industry. Mental ill health, in its most severe form, is the greatest unsolved problem confronting the medical profession to-day. Its milder manifestations result in great personal unhappiness and an untold amount of inefficiency. Mental hygiene claims to offer little more than a rational inquiry into the causes of mental disorder and human maladjustment, with the implication that with professional groups rests the responsibility for developing a future program along sound fundamental lines.

Man progresses by evolution rather than by revolution, and a steady, consistent development of mental hygiene in professional fields is far preferable to a hasty acceptance and exploitation of it by quasi-scientific or popular groups. The psychiatrist has been accused of making unjustifiable claims for mental hygiene. It is said that mental hygiene has been oversold. We might say that, instead, mental hygiene has been overbought. The movement has perhaps suffered somewhat at the hands of its friends. Nevertheless, the unwarranted enthusiasm of a few does not affect the validity of our inquiry into important interpersonal relationships.

There have been few established landmarks by which our course might be charted. A lack of lucidity is to be expected because we are trying to establish an area, at present ill-defined, in which the thinking of various professional groups may find a common denominator. One of our mutual shortcomings is that we have difficulty in expressing ourselves in terms that can be readily understood. Speech is inadequate at best, and we often overlook the obvious fact that it can be used both as a vehicle for communicating our thinking to another and as a defense of our own inadequacy. How often have we hidden our ignorance in scientific terminology, high-sounding phrases, and a cloak of mystery. It might be well to indicate that no one of us is infallible, that we are seekers after truth, and that the admission of a lack of knowledge may be the mark of a secure man and a mature personality.

The necessity to know is often confused with the need to know.

Religion is an attitude of man influenced by many factors. In the beginning, it concerned itself almost exclusively with the mysteries of life. This is less true to-day, at least of modern religions, but Christianity is by no means universal, and a considerable part of the population of the earth is still preoccupied with interpretations of that which is little understood. Crop failures, defeat in battle, pestilence, and assaults of wild beasts were—and for large numbers of the human race still are—indications of the displeasure of the deity. Religion became a universal method by which man attempted to explain his existence on this earth, to provide for his satisfactions and his securities, and to look forward to a life hereafter. In the realization of these aims, he has not been altogether successful. The hazards imposed by a competitive and rapidly changing social structure have been many. A completely successful adaptation is something that people strive for, but few there are who can count it as one of their achievements.

Many daily occurrences have little meaning unless they can be transposed into something that has emotional value. Radio-activity as such is to most of us a phrase of doubtful significance; transposed into music, however, the term takes on meaning according to the importance music may have in our daily lives. In a similar way religion depends more upon feeling processes than upon pure intellectualization. May it be that there are as many types of religious conviction as there are feeling experiences and that the wide variation in these experiences is responsible for our conflicting dogmas, all of which may be true in some groups, among some people, at some time? Psychiatry is interested in the emotional life, the feelings of the individual. It becomes related to religion when both attempt to find a common denominator in the field of behavior and to establish some scientific method by which feelings may be interpreted and understood.

In discussing psychiatry and religion, it may be well to point out similarities and differences. I am convinced that often we are talking about the same thing when we discuss the individual and his adjustment. We both want for him the best of which he is capable. The psychiatrist is interested

in the varying potentialities of individuals. Religion is interested in the expression of those potentialities in terms of group behavior. The minister has become the spokesman for society, which demands a certain adaptation on the part of the individual. The psychiatrist is the spokesman for the individual, and is interested in the reasons why adaptation has failed and the ways in which it may be improved. The minister is concerned because the individual misfit causes a lack of unity in the group as a whole. The psychiatrist is interested in group behavior chiefly from the standpoint of its effect on the individual. In religion the minister must stay in the picture and become an influential part of it. The psychiatrist, however, attempts to erase himself as an influencing factor; his efforts are not directed toward reforming the patient—rather, he hopes that the patient will himself develop the capacity to conform.

In considering any individual, we must evaluate his cultural pattern. If he is failing to adjust to the behavior of the group, then there are possible explanations: the group pattern may be too inflexible; the early experiences of the individual may have rendered it impossible for him to adjust. If we are to be helpful, we must be aware of all the factors that assist or inhibit the integrative process. In this the minister has too long been an isolationist. Have not the specialties of medicine, psychiatry, sociology, and social work much to offer that will increase our knowledge of individual behavior? May it not be within the province of the psychiatrist to indicate certain areas in which he and the minister may function both individually and in a coöperative relationship? The minister, whether he chooses to be or not, is already in the mental-hygiene field; the choice that he has to make has to do with the kind of mental-hygienist he would like to be. No one professional group has a monopoly on effort that has as its goal human betterment. We should be challenged to participate in a coöperative enterprise that has so much to offer. The mental-hygienist of the future will be the minister, the teacher, the parent, the family physician, as well as the psychiatrist.

Psychiatry subscribes to the doctrine of "the totality of the individual." Specialists in various human relationships have been prone to regard their own fields as quite specific

and their own techniques as quite adequate for the problems involved. In this none have erred more than the physician, who all too often sees disease processes only in terms of a disordered bodily physiology. His efforts to effect a cure have been directed along conventional lines of surgical procedure, the administration of drugs, or advice as to habits of work or play. We now know that such serious conditions as bronchial asthma and gastric ulcer often result from emotional conflict and that recovery occurs when that emotional conflict is alleviated or removed. The teacher in the classroom has regarded education as a matter of application to the task at hand, its progress being largely determined by the diligence of the pupil. Recently, such factors as variations in intellectual capacity, physical conditions, and emotional frictions in the home have become of concern to the teacher to an ever-increasing degree. Has the clergyman been guilty of the very human error of occupying himself too exclusively with the material at hand—the finished product—and would he be a better mental-hygienist if he were more aware of the influence of all the life experiences that have collaborated in making the person what he is to-day? In this effort to grasp the doctrine of the totality of the personality, medicine and psychiatry, as well as psychology, sociology, and social work, have valuable contributions to make. It is the utilization of concepts in allied fields, not the adoption of the techniques of other specialists, that is important in the clergyman's efforts to bring mental-hygiene values into his ministry. Adapting the concepts of others and reformulating his own to meet new and ever-changing human needs presents a constant challenge.

Wide publicity has recently been given to books and articles written by clergymen on mental health and psychiatric subjects. I would add a word of caution. I deplore any effort to make a poor psychiatrist out of a good minister. I should like to quote from an address made by Reverend C. A. Wise, Chaplain of the Worcester State Hospital, before the American Association for the Advancement of Science in 1938: "If the clergyman has a contribution to make to the mental health of the parish and the community, he will make it as a clergyman and largely through the usual offices and relationships of the clergyman." There are no short-cuts to the under-

standing of human problems for either the minister or the psychiatrist. We must begin with the present state of our knowledge, adopt the attitude of the student—one who wishes to learn—and maintain flexibility of thought with reference to the contributions of others who are interested in the various ramifications of this subject. I believe we have a mutual responsibility to the patient to refer him to the one best equipped to treat his specific problem.

It is difficult to indicate just what the individual minister should do in the field of mental hygiene. Even as some physicians excel in the field of diagnoses and are little interested in treatment, some ministers are known for their organizing and administrative ability. It is largely up to the individual clergyman to decide where his interests lie and whether or not he has the capacity to deal with people on a rather deep emotional level. I would not recommend that all ministers attempt extensive counseling programs, any more than I would recommend that all physicians become surgeons.

What approach, then, should the minister develop to mental hygiene in his parish? In the first place, I believe that he should be thoroughly familiar with the social agencies in his community. He should know where people may be referred in times of illness, financial crisis, or unemployment. He can contribute much as a member of an executive board of a social agency; the agency stands to profit by his wisdom and experience.

Again, there is no other professional person who has access to so many homes in such a variety of situations as the minister. I suppose that no other person, not even the physician, has such an opportunity to recognize early signs of mental disorder. Families often dismiss mental upsets in their members as "nervousness," feeling that they are a disgrace, that their effects will be only temporary, and that time will solve the problem. The minister's counsel is of great value to the family whose thinking has become so subjective that a clear conception of the best procedure to adopt for its ill member is impossible. The Council for the Clinical Training of Theological Students has recognized the value for the clergy of a better understanding of mental disorders and over a twelve-year period of time has given training in mental hospitals to 275 persons from 42 schools of theology, repre-

senting 22 communions. Seventy-five per cent of these people are now in the pastorate.

I think that the minister should know psychiatrists and their points of view in order that he may use their services for his people. I hope that his tolerance of human shortcomings and error may include us, too. We have much to learn from each other and our objective is not agreement in all phases of our work, but rather an amalgamation of constructive philosophies in order that we may help those in distress.

I believe it is wise to be aware of the possible physical contributions to emotional maladjustment, and I earnestly recommend a complete physical examination for emotionally ill people. There is no need to call attention to the effect of an early thyroid disease, often difficult to diagnose, upon the emotional reaction of the patient. The disorganization of the adolescent is often due to changes in glandular systems that are not yet working harmoniously with one another. Depressions in late life are likewise greatly affected by a changing physiology and many become frank medical problems. The minister cannot wisely assume that there is no relationship between that which is mental and that which is physical.

In what kind of psychological setting does the patient find himself when consulting his minister? His mind is often in turmoil, and his distress is very evident in his facial expression, his voice, and his physical mannerisms. We may say that the chief function of the minister at this point is "to listen." He becomes a sort of emotional "sounding board" upon which the patient may reflect some of his own thinking. Talking often clarifies the problem. Psychiatry is firm in its decision to refrain from any act that would permit the patient to feel that his conflicts are being divulged in a critical, unfriendly atmosphere. Fear of criticism keeps many people away from the one best equipped to help them. There are those who feels that any tolerant attitude toward misbehavior amounts to a sanction of it. I would point out that the patient is well aware that neither the church nor society sanctions his misbehavior, and an unbending attitude will often drive the distressed person away.

A word of warning should be uttered, however, on this matter of allowing the patient to unburden himself—to talk

out all his problems. There is a bit of danger in this process, and the listener should be aware of the terrific sense of guilt that often follows mental catharsis. Better to interrupt an interview and make another appointment than to run the risk of arousing feelings of guilt and unworthiness through a complete unburdening. We often overlook the fact that a guilty conscience can and does inflict a terrific amount of punishment. A sense of guilt can be alleviated and diluted to the point where the patient obtains great relief in talking over his conflict, and he often leaves the interview feeling that you do not reject, but understand him and will see him safely through his difficulties. Confidence cannot be forced, but must await the decision of the patient. Information gained by "probing" is of doubtful value, and is frequently distorted to save the feelings of both parties concerned. A sense of guilt does not make for free discussion except when the possibility of criticism is at a minimum.

Is it wise to assume that all people will be able to find complete religious satisfaction in a church affiliation in which they have been precipitated by chance, by family training, or by their own search for religious security? Some people are more secure in a church in which worship is formalized, in which religious teaching and practices are inflexible, while others demand a certain freedom of thought and action, more in keeping with their own ideas of what religion should mean to them. I believe the day is past when people accepted religious belief as an answer to all the problems of life or attempted to explain everything that happened to them in terms of this religious belief. Modern life has become much too complicated, and personality factors not present several generations ago are demanding more and more consideration. Should the minister give more thought to the personality pattern, its need for a rigid adherence to religious teaching or the reverse, and use the insight thus gained in directing the patient to the church in which he will find solace? This may be a somewhat radical point of view, but the number of people who drop out of church, for whom religion is merely a formality, who change religious affiliation without benefit of clerical advice, or who associate themselves with fanatical sects, is some indication of the extent of this problem.

Much has been said about the function of the minister in

the field of marriage counseling. We are not yet quite certain of the ingredients that go to make a successful and happy marriage. The sociologists have made many studies of common factors present both in marriages that have succeeded and in those that have failed, but we are still in need of many more facts than are at present available. We need not only a comprehensive study of a large number of unsuccessful marriages, but also a similar study of happy marriages, in order that the validity of our findings may be tested. No one can assume that this would do much more than indicate the more general areas of conflict. Satisfactory answers to human problems have a way of continually evading our most careful efforts to find them. The minister is likely to formulate his ideas on marriages from a few observations of those that have succeeded and those that have failed. He obviously overlooks the fact that he is dealing with a highly selected sample and often makes the mistake of assuming that if a fact is true of a small number of people, it must be true of the general population.

For example, our general population may be divided into church-goers and non-church-goers. The church-goers—those who are most likely to come to the attention of the minister—may be divided into those who are happily married and those who are not. Those who are not happily married can be further divided into those who will consult their minister about their unhappiness and those who will not. It becomes evident, therefore, that the minister is not justified in making many assumptions as to why marriages are failures solely on the basis of his experience with the people who come to his office. No two marriages are alike—but there must be factors, personal, religious, and economic, that are common to all.

Marriage as an institution has always been one of the bulwarks of the church. The forces that collaborate in making successful or unsuccessful marriages are never static, but are continually changing. The minister, with his strong interest in the family and its welfare, is apt to overlook many fundamental biological and personal considerations. The unrest among the youth of our country is a case in point. The present generation of young people are asking many questions for which society has no adequate answers. Many modern women are experimenting with their new-found

freedom, contrary to the pattern followed by great-grandmother. They have sought and found professional, literary, social, and artistic satisfactions outside of their homes. Many are, in addition, thoroughly convinced that they have not only a right, but an obligation, to limit the size of their families.

Marriage is never the solution to a personality problem. It not only enhances the problems already existing, but usually initiates many new problems. The psychiatrist has found that there are certain types of people who are unsuited to marriage and whose personalities cannot possibly adjust to a marital partner. We have an obligation to keep people unsuited to each other from marrying, even as we have an obligation to contribute to a marriage that appears to have all the ingredients for success. The problem is too big for either religion, medicine, or sociology to deal with alone, and perhaps a pooling of our interests and knowledge will eventually result in something more than a compromise with one of modern society's most perplexing problems.

I believe that the vast majority of sexual problems fall within the province of the physician. The sex instinct is one of the most fundamental elements of the personality and problems in the sexual field and their ramifications are difficult both to understand and to treat. A sexual problem makes its appearance because, from birth on, nature and environment have combined to lay a foundation upon which it may rest. The fact that its appearance is delayed until middle or late life does not render the matter less important or easier to treat. In fact, the reverse seems to be true. Regardless of one's own opinion on the matter, the efforts of specialists in other fields to understand and interpret the dynamics of the sexual instinct should not be ignored.

The rôle played by the symptom has misled many. A mother brings her boy to the clinic asking that he be cured of his stealing. An attendance department refers a boy to the court because he is truant from school. A chronic alcoholic wishes to reform and return to his family. A preoccupation with symptoms is fairly unprofitable; the roots of behavior lie deep in the structure of the personality and superficial treatment often results merely in a change in the presenting symptom. The truant from school may attend regularly, but begin to disobey his parents and to abuse his

younger brothers and sisters. The symptom may be only remotely related to the real difficulty. Many patients cling tenaciously to their symptoms for years; recovery means facing or returning to emotionally untenable situations.

There will be many moments when the minister will be tempted to offer words of advice. I am very reluctant to accept the validity of this procedure. The patient may think that he wants advice; the minister may feel called upon to give it and may think that he knows the answers; all may be wrong. The value of a decision reached by one's own thinking processes can never be disregarded. The minister should attempt to clarify the problem by developing both sides of the situation, and the patient will often be able at that point to take a more objective attitude. The psychiatrist has been criticized in many circles because he refuses to advise, to sit in judgment, or to formulate a life plan for his patient. We should assist the patient and support him in making his own plans, but have we a right to thrust upon him a plan of action not of his own making? At this point I am certain many will disagree. Emotional conflicts continue to increase, however —laws, rules, regulations, and social prohibitions to the contrary. If we propose to help the patient, we must not content ourselves with the formulation of a new plan, but we must attempt to ascertain the reasons why the previous one failed. Certain advice comes under the heading of "useless admonition." Where is the physician who has not said to his nervous patient, "Forget your troubles and quit worrying. Keep busy and don't think about yourself"? Has the minister also fallen into this very human error when he counsels, "Have more faith"? Worries and fears cannot be conquered by forgetting, well-meant advice to the contrary. This is the mechanism that has usually precipitated the patient into his unhappy state.

Man's conflict with his world is increasing, whether we look at the citizen of our own country and contemplate his efforts to promote security for his family, or the citizen of the totalitarian states who is by the use of aggression and force trying to do the same thing. Totalitarianism as a way of life has become what religion should have been. For years religion, education, and medicine have been concerned with the destiny of man, each in its own way. Psychiatry has to

offer a point of view—the totality of the personality. Everything experienced by the individual, be it remembered or not, has become a part of the personality. Quoting again from Reverend Wise: "Religion, which ought to concern itself with the whole of life, almost succumbed to the method of isolation and analysis. The movement present in some biological and social sciences to-day, which emphasizes the need of studying the organism as a whole in its relation to its total environment, may therefore be accepted by the investigator of religion as embodying a principle on which he should have been working all the time."

The minister can make his approach along traditional and conventional lines or he can amplify his methods by considering techniques and interpretations from other specialists working in the field of interpersonal relationships. Dr. William Healy, in his excellent book, *Personality In Formation and Action,* gives us a closing thought: "In this year of grace we have traveled only a comparatively short distance on the sea of knowledge and personality, but we have gone far beyond the conception that 'Time,' the ocean and some far-off star have entered into cabal to make us what we are."

THE UTILIZATION OF THE STATE HOSPITAL IN THE TRAINING OF PSYCHIATRISTS *

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PRESENT standards for the certification of specialists in the field of psychiatry and neurology are the natural result of policies that have undergone formulation and reformulation over a period of years. It has been a logical development, gradually attained and never before crystallized, probably because of an insufficiency of approved training centers to meet the demands created by the setting of standards; obviously it would have been impracticable to require a quality of training that could not at the time be provided.

This situation has not changed entirely, but with the gradual improvement in our mental hospitals, some of them have become educational centers which, with some modifications, can be made entirely adequate. This refers in large part to state hospitals, which, with their wealth of material, have heretofore supplied the largest number of physicians to the specialty of psychiatry. Unfortunately they undertook little in the way of formal training, and dependence was placed on an apprenticeship type of learning which, although successful in a small percentage of cases, too often produced an unsatisfactory, armchair, vocabulary type of psychiatrist, adept at housekeeping duties, but failing signally when it came to meeting the deeper needs of his patients.

This is not intended as a condemnation of that phase of psychiatric training, for it was a necessary stepping-stone to the present, but because of its failure to utilize the more recently developed types of knowledge, its accomplishments

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were limited. Present developments demand a broader foundation, and hence the scope of training will of necessity have to be extended and its quality improved.

It is evident, from the requirements of the American Board of Psychiatry and Neurology, that mere unorganized experience in any type of mental hospital will not in the future qualify one for entrance to the board examinations. Therefore, if the need for qualified psychiatrists is to be met, it behooves those state hospitals that have resources with which to meet the standards to supply the basic training for those who desire it.

Men who seek state-hospital positions are of two types—those who are content with a routine job and those who are sincerely interested in psychiatry and who seek such training as will be acceptable for certification. The latter group supplies the most valuable additions to a staff. In order to obtain them, it will be necessary for the hospital to furnish teaching that will be acceptable to the board.

On this basis, mental hospitals will fall roughly into three classes: (1) those that give full instruction in all branches, with extended training for those who show particular aptitude; (2) those that give only extended experience in the clinical field; and (3) those whose practices are so far below the mimimum standards as not to warrant recognition of any sort. Other things being equal, the better the training offered, the wider the choice of personnel. It is not to be anticipated that this rather strict alignment will come about overnight, but with the increase of pressure for proper training, there should be an acceleration of the heretofore slowly developed method of supplying qualified psychiatrists.

Nothing in this paper is to be taken as implying that strategically placed psychopathic hospitals, preferably in connection with medical schools, can fail to be an important and necessary part of a general scheme of training. They should be able to offer a highly organized arrangement for working out problems of research that are beyond the scope of the average state hospital. They have a specialized function, related to, but outside, the realm discussed here.

To repeat, the state hospitals offer the only existing set-up sufficiently large and evenly distributed to train in

adequate numbers psychiatrists who can meet the higher standards.

To be utilized as a training center, the state hospital must meet certain necessary specifications:

1. It should be near enough to a medical center to have access to library facilities beyond the means of the average state hospital. Libraries, consultants, and other facilities are available only in such locations. This does not relieve the hospital from the duty of providing a library adequate for routine collateral reading.

2. It should be basically sound and should meet at least the minimum standards of the American Psychiatric Association.

3. It should maintain a training school for psychiatric nurses.

4. Beyond this it should be imbued with an investigative spirit and a healthy curiosity about all the problems that confront institutions of this sort. Absence of fixed ideas and allowance for freedom of investigative tendencies under guidance should be fundamental.

All these characteristics can be attained under stimulating leadership. Affiliation with the nearby medical school is desirable and necessary if the requisite teaching personnel is to be maintained. Such affiliation will be welcomed by the average medical school because of the added material and teaching facilities to be gained by exchange. In the present state of psychiatry, multiple contacts and varying points of view produce a broadening of instruction that cannot be attained in any other way.

Through this affiliation, there might also be developed, in those institutions so inclined, the additional teaching personnel that is much needed in the medical schools. This closer contact will bring to the undergraduate a clearer appreciation of psychiatry as it relates to him. Psychiatry will never achieve its objectives until it meets satisfactorily the need of the medical student for knowledge that he can use in whatever specialty he may practice. State hospitals do not abound in good teachers, but they do have an unusually large number of physicians with clinical acumen who can do much in the way of stimulating and guiding the interest of the beginner.

Experience tends to teach that the state hospital is the only place in which a physician can be satisfactorily trained for the practice of psychiatry in another state institution. All the didactic instruction in the world will not qualify a man to enter upon the duties of an assistant physician if he is not oriented to the customs, habits, and practices of these hospitals. It is, therefore, necessary to maintain the staffs of these institutions on a working level before they can function in the matter of supplying personnel for the other branches of psychiatry. They will be the backbone of the psychiatry of the future as they were of the past.

Before proceeding to an outline of instruction, let us give some consideration to the candidates for training. They should be graduates of acceptable medical schools who have served an approved internship, and, if possible, preference should be given to those who have had some experience in general practice, provided their interest in psychiatry is sincere. There will be all types of personalities, some fitted for the specialty and others who will prove inadequate. The personality type must be taken into consideration in plans for each individual. It is well if his desire has led the physician to a field for which he is suited. One should not, however, encourage him to endeavors beyond his abilities or his personality qualifications. Such encouragement is nothing short of injustice.

The beginner should be told of the pecularities of life in a mental hospital—that it is a small community with more than the average number of gossips; that every action will be scrutinized and perhaps misinterpreted—and warned how cautious he should be until he has had enough experience to be able to sense criticism. Even a university graduate may have to be advised about ethics, social contacts, circumspection, and other personal matters. It is the rare individual who does not require these cautions.

The individual's personality should be utilized to the greatest extent and capitalized. Psychiatry still has room for many types. If we are to exclude any, let it be the markedly warped, biased personality whose emotional blind spots will ever prevent his having any deep appreciation of the problems of others. Training for psychiatry should be

directed toward meeting the needs of the patient and the community rather than the psychobiological deformities of the trainee.

Once the individual has been found acceptable, he should be taken on a definite contract, similar to that of an intern, with an agreement to remain for the basic training period. If after six months a beginner feels that he is equipped to practice the specialty, his agreement will tide him over this period. A certificate should be given for its satisfactory completion.

To proceed to the actual institutional set-up for training, may I repeat that the hospital should meet at least the minimum requirements of the American Psychiatric Association. These are listed below for ready reference:

> "1. The chief executive officer must be a well-qualified physician and experienced psychiatrist whose appointment and removal shall not be controlled by partisan politics.
>
> "2. All other persons employed at the institution ought to be subordinate to him and subject to removal by him if they fail to discharge their duties properly.
>
> "3. The positions and administration of the institution must be free from control for the purposes of partisan politics.
>
> "4. There must be an adequate medical staff of well-qualified physicians; the proportion to total patients to be not less than 1 to 150 in addition to the superintendent, and to the number of patients admitted annually not less than 1 to 40. There must be one or more full-time dentists.
>
> "5. There must be a staff of consulting specialists at least in internal medicine, general surgery, organic neurology, diseases of the eye, ear, nose, and throat, and radiology, employed under such terms as will insure adequate services. A record of their visits must be kept.
>
> "6. The medical staff must be organized, the services well-defined, and the clinical work under the direction of a staff leader or clinical director.
>
> "7. Each medical service must be provided with an office and an examining room containing suitable conveniences and equipment for the work to be performed, and with such clerical help specially assigned to the service as may be required for the keeping of the medical and administrative records.
>
> "8. There must be carefully kept clinical histories of all the patients in proper files for ready reference on each service.
>
> "9. Statistical data relating to each patient must be recorded in accordance with the standard system adopted by the Association.
>
> "10. The patients must be classified in accordance with their mental and physical condition, and with adequate provision for the special requirements for the study and treatment of the cases in each class, and the hospital must not be so crowded as to prevent adequate classification and treatment.

"11. The classification must include a separate reception and intensive study and treatment department or building, a special unit for acute physical illnesses and surgical conditions, and separate units for the tuberculous, and the infirm and bedfast. Each of these units must be suitably organized and equipped for the requirements of the class of patients under treatment.

"12. The hospital must be provided with a clinical and pathological laboratory, equipped and manned in accordance with the minimum standards recommended by the Committee on Pathological Investigation.

"13. The hospital must be provided with adequate X-ray equipment and employ a well-qualified radiologist.

"14. There must be a working medical library and journal file.

"15. The treatment facilities and equipment must include:

a. A fully equipped surgical operating room.

b. A dental office supplied with modern dental equipment.

c. Tubs and other essential equipment for hydrotherapy operated by one or more specially trained physiotherapists.

d. Adequately equipped examination rooms for the specialties in medicine and surgery required by the schedule.

e. Provision for occupational therapy and the employment of specially trained instructors.

f. Provision for treatment by physical exercises and games and the employment of specially trained instructors.

g. Adequate provision for recreation and social entertainment.

"16. Regular staff conferences must be held at least twice a week where the work of the physicians and the examination and treatment of the patients will be carefully reviewed. Minutes of the conference must be kept.

"17. There must be one or more out-patient clinics conducted by the hospital in addition to any on the hospital premises. An adequate force of trained social workers must be employed.

"18. There must be an adequate nursing force, in the proportion to total patients of not less than 1 to 8, and to the patients of intensive treatment and acute sick and surgical units of not less than 1 to 4. Provision must be made for adequate systematic instruction and training of the members of the nursing force.

"19. Mechanical restraint and seclusion, if used at all, must be under strict regulations, and a system of control and record by the physicians, and must be limited to the most urgent conditions."

It is assumed that the hospital is one of from two to three thousand beds or larger than this if it is properly integrated. A hospital of less than two thousand beds can hardly maintain the necessary background, unless funds are available for the added expense incidental to the training program. With sufficient beds, there should be adequate segregation and separation of patients, to allow for their proper classification. This is important because proper treatment is predicated upon it.

There should be a definite rotation of those in training between the various services, and there should be a large enough group in training to permit of unhurried utilization of the various services, in addition to such time as will be required for didactic instruction, collateral reading, and extramural activities.

The basic training period should cover at least eighteen months, divided about as follows: reception (psychopathic, receiving) hospital, six months; infirmary (aged and infirm, epileptic, tuberculous), three months; subacute (continued care), three months; working (chronic) services, three months; laboratory and X-ray, three months. Mental-hygiene-clinic attendance may be carried with other assignments, as well as attendance at staff, clinico-pathologic, and other conferences. This out-patient work should start after six months of residence.

These services, with the possible exception of the receiving service, will be duplicated for male and female patients, and assignments should be alternated between the sexes. If the receiving services also are divided, three months should be given to each.

Those who show particular aptitude should be invited to remain, at an increase in salary, for an additional eighteen months and be used as instructors in the various laboratory and didactic courses. During this second period, they can investigate some simple problem of research within the facilities of the hospital.

The responsibility for assignments, for coördinating instruction, and for immediate supervision, and any arrangements pertaining to the trainee should be in the hands of the clinical director. It is to be assumed that he will also have charge of the training of nurses, attendants, and other personnel, as well as supervision over all the clinical work of the hospital. Without such an arrangement there will be little coördination of training, and it will prove futile. Needless to say, the clinical director should be free from all except a minimum of administrative duties.

Each service assignment will carry with it definite items to be stressed, and a card listing the items for particular study should be given the trainee at the time of his assign-

ment to the service, this to be in such form as to serve also as a record of work done and investigations carried out. Constant contact by the senior in charge of the service and by the clinical director will keep the record of the trainee's progress up to date.

It is not possible to give in detail here what these various services should offer, as this will vary in different institutions, but a brief consideration of each service will indicate the general plan. Obviously, under a system of rotation, some will start in the laboratory, others in the infirmary service, and so on, and this will modify to some extent the method of instruction in individual cases. As a practical point, those who show what seems to be only a verbal interest in psychiatry should be started in the infirmary wards. This will test their interest, and if they stick it out, they are pretty certain to go on. The principle is the same as that of the ophthalmologist who started all his postgraduate students on six months of nothing but refraction to see if they were really interested.

Reception Hospital—Here one meets the acute problems as they are brought from the home, the police station, the courts, other hospitals, social agencies, and wherever else they are found. The beginner learns here to deal with representatives of these various community agencies and with distraught relatives in their first contact with a mental hospital. He should not be expected to handle these acute situations, but should sit in on initial interviews with the patient, with the family, and with the agency representative. He should watch an adept handle these problems and learn from him how to meet the many situations presented. The importance of these initial conversations should be stressed to him and the significance of their ultimate implications pointed out. Proper admission of a patient settles a great many difficulties at one time. Here the beginner will have a chance to inspect commitment papers, and the various forms of commitment can be illustrated by the papers upon which the patients are admitted. Also, the legal aspects of certain cases, such as those of trauma, homicide, or assault, can be pointed out as possibly leading to court action that will require testimony by the physician. Questions will arise

concerning the appointment of a conservator, the legal relationship of husband and wife, testamentary capacity, the signing of legal documents, the endorsing of checks, the assignment of property held by the hospital, and a great many other matters.

The beginner should be able to follow patients to the ward, to study their reactions to hospitalization, to assist in initial physical examinations and learn the art of accommodating the patient to his first mental-hospital experience. He should receive supervision, counsel, and direction in working out case histories, and the first records should preferably be made in longhand, with constant reference to the case-history outline.

The beginner should consult constantly with the psychiatrist as to the progress of his investigations and be counseled how to proceed next. So many beginners leave their knowledge of medicine on the front doorstep when they enter the institution for training that it is necessary to remind them that a delusion and sugar in the urine may in some way be related. They must be taught to follow up positive physical and laboratory findings with appropriate additional investigations. Neurological signs indicate detailed examination of the nervous system. The personal possession of an ophthalmoscope and other necessary instruments for ordinary examination should be a fundamental requirement.

The physician should be assisted with the care of his patients and the rationale of therapeutic procedures. Here he can familiarize himself with nursing procedures, with various forms of hydrotherapy and their indications. Prescription for these measures and for drugs should be made under supervision. There should be definite questioning by the psychiatrist as to the rationale of the treatment, and in the case of drugs, an explanation of their pharmacology and their applicability in any given case.

The trainee should be taught to meet the various types of problem presented by patients, such as resistiveness, aggressiveness, muteness, refusal of food, assaultiveness, facetiousness, erotic behavior, depression, suicidal tendencies, and other types as they arise. He should learn the methods of tube feeding, the preparation of tube-feeding diets, the pre-

scription of special diets in keeping with the articles obtainable within the hospital budget, and the judicious use of sedatives. In dealing with relatives, he should be taught how to discuss the patient's condition, and how to obtain additional data which the relatives may have been too upset to give at the time of admission. He should learn to control his own feelings, to be as objective as possible, but sympathetic, and to develop the art of feeling his way into the problems of the patient and his relatives.

Subacute or Continued-Care Services—This varies but little from the receiving service except that the patients and relatives have become familiar with the situation and the problem of contacts has changed its aspect. Relationships on both sides have usually settled down to a fairly comfortable level, but the interest of the relatives is sustained. Adjustments are more gradual, but equally important, since the physician's decisions are somewhat more definite and likely to lead to a withdrawal of assistance on the part of relatives unless considerable circumspection is used in interviews with them. We still have potentially retrievable material, and if we can maintain the family help, it may make the difference between a return to the community and prolonged hospital care. The beginner should be made to feel this difference, and again his contacts with relatives should be supervised and his judgments guided.

These services have to do with large groups of patients, and administrative functions become more prominent, overshadowing the interests of the patient unless perspective is maintained. These administrative functions should be pointed out, and the trainee should be made to realize some of their intricacies as they affect his relations with the patient, the hospital, and the relatives. The preservation of grandmother's false teeth, the proper care of Sally's silk stockings are as important matters in the eyes of relatives as a profound knowledge of the delusions of either. Carelessness concerning their property means to the relative a lack of training in the medical aspects of the disorder and detracts from confidence in the doctor's ability. Therefore, unscientific as the subject matter may seem, the neophyte must be impressed with the seriousness of a hole in a silk stocking and be taught to explain its existence as frankly as he explains

the patient's lack of love for her mother. These are all phases of dealing with the patient as a whole, including his environment, both inherited and acquired.

This is, of course, the type of thing the physician would have to face were he in private practice. He must learn, if he does not know it already, that the average person seeks, not advice, but some one who agrees with him. This service should also offer the opportunity to learn how relatives play the patient against one another and attempt to make the hospital physician pull their chestnuts from the fire. He can do a great deal toward drawing the family factions together, allowing them to bump heads and leave the hospital and the patient in the clear. Service of this kind is an obligation that he owes the patient for whom he is responsible. He should likewise be on the lookout for apparently well-meaning friends or relatives who want the patient to sign something, or who wish a certificate of some sort concerning the patient's condition. These are minor details of the more important medico-legal implications, but they may be important in their repercussions. Continued attention to legal details and attendance at court in matters concerning patients will give the beginner further experience in the methods and logic of the legal profession.

This service also supplies opportunities for continued study of nursing procedures, of hydrotherapy and occupational therapy. Cases requiring prolonged treatment are housed here, and unless there is a special clinic for the treatment of syphilis, it will be treated on this service. Cases of pregnancy with psychosis, of cardiovascular disease in younger patients, of endocrine disorders, anæmias, and gynecological and genito-urinary conditions must be dealt with in a state complicated by mental disorder.

At no time should the beginner be allowed to subside into a state of armchair rumination; his nose should be kept constantly to the grindstone of medical practicality. He should be taught the newer methods of therapy in the psychoses and trained to be constantly on the alert for changes in his patients that indicate a new method of approach. The bizarre and the unusual always attract the beginner, and constant guidance is necessary to bring him back from such distractions to the commonplaces that constitute the bulk of

his problems. Continued dealing with relatives should provide insight into family relationships out of which the patient's psychosis may have grown.

In all of this, the beginner needs guidance from the physician in charge of the service, who should not sit back and say, "Thank goodness, I have some one to help me and can turn these things over to him." That is not training, and the respite is usually brief, the end result being a multiplication rather than a diminution of problems.

Patients undergoing psychotherapy will be found on these services, and the psychotherapist should give some time to the beginner, pointing out the procedure in use and guiding his attitude toward the patient and, in a coöperative spirit, coördinating the patient's activities with the therapeutic endeavor. Psychotherapy, in itself, is no be-all and end-all, but only a part of a prescribed régime. True, the beginner is in no position to think of doing psychotherapy himself, but he should have some appreciation of its significance as it affects his patients, and at some point must be introduced to it, if he is ever to employ it himself.

Methods of hospital administration applied to this type of service should be taught him as he proceeds, and if he has had other services previously, its differences from these should be pointed out. The care of different types of patient, the management of various types of ward, the judgment of a patient's condition by casual observation, are points to be stressed on a service where a constant influx of new patients, not entirely adjusted to the hospital, makes quick judgment in such matters imperative. Actual interviews for continued notes will assist the beginner in checking his own judgments, and with this check he should learn to improve them.

Working, Chronic Service—This type of service offers a natural gradation from the subacute wards. It is made up of patients who are convalescent, but who need to make a further adjustment in the hospital before going home, and of those who have adjusted to the hospital at a working level, but whose psychoses continue at a point that prevents their rehabilitation in the community. It supplies workers to the hospital utilities and is, therefore, important from an economic as well as a therapeutic standpoint.

There is much for the beginner to learn in a commonplace

service of this sort, if he can but briefly be distracted from the functions of the hypothalamus. Aside from his notes, which involve an interview with the patient and with his employer, there should be study of the conditions under which the work is carried on. The beginner should familiarize himself with the job that the patient is doing—what physical labor is involved, what intelligence is needed, what the patient's attitude is toward it, and how well he is meeting his opportunities.

The beginner would do well to spend some time with the manager of each utility, determining its place in the functioning of the hospital and what problems it has to meet. In that way the ward service can help to solve these problems. It is here that the beginner comes in closest contact with pure hospital administration, and although he may not be interested in it as such, he can never function as an efficient hospital physician until he does have some understanding of these non-medical functions. Let him follow his patients to the farm, the dairy, the power house, the laundry, the industrial shop, the grounds maintenance, and wherever else they go, if he would understand the machinery that allows him to function as a hospital physician. From this he should learn how his every order may have repercussions in all these departments, mostly unseen and in large part forgotten by those in the clinical field.

The management of patient labor is important economically and is a form of personnel management, with all the implications thereof. There are considerations of working hours, days off, industrial hazards, physical fitness, aptitude, turnover, and so forth, which keep the physician in charge of such a service constantly on the alert to the interests both of his patients and of the hospital. Preparation for psychiatry should include a study of this service as part of the concept of the individual as a whole. In private practice the physician would not dare to ignore matters that occupy the major part of his patient's time.

Infirmary, Tuberculous, Epileptic Service—Depending upon the buildings available, these services will be housed in the same or closely related buildings. The essential problem is the same—that of caring for the chronically ill, most of whom

are physically incapable of being usefully occupied in the institution. Each group, however, has features that are peculiar to it, and the beginner should have sufficient contact with each to familiarize himself with its special problems. The aged and infirm offer an unequaled opportunity for studying diseases that are common in this period of life—arteriosclerosis, malignancies, cardiac disorders, and the conditions incidental to them. One has access here to records of patients who have been cared for under standardized conditions for many years, with a detailed study of their life histories and of the end results. Mental conditions characteristic of the later years of life are found here in abundance, and if advantage is taken of the opportunity, under proper guidance one will become familiar with these during one's stay on the service. Here also will be found many types of neurological syndrome which can serve for the basic and clinical courses in neurology. It is important that the trainee learn something about the dietetics of the aged and about nursing care for old people who must be kept in bed for months on end. Here he has also a different type of contact with relatives, and the administrative problems are distinct from those of any other type of service.

On the tuberculosis wards, he sees this disease in all its stages and learns something of the problem of preventing the infection of other patients and of employees. He can also learn the methods of detecting early cases in patients who do not complain and cannot coöperate and who are potential sources of infection, being housed with patients who are not yet infected. Also to be considered are questions of the choice of diet for them and the problem of maintaining nutrition under unfavorable circumstances.

The trainee can familiarize himself with the types of personality afflicted and their various responses to the disease, regardless of the different strains of the infecting organism. He can assist with surgical procedures and study the response to these in the mentally ill. The detection, prevention, and treatment of pulmonary tuberculosis represents one of the more important problems in mental-hospital administration, and it is one that is not yet solved. A closer study of this sort should go far toward its intelligent solution. Since

roughly 5 per cent of any mental-hospital population is actively infected, the serious proportions of the problem are obvious.

Epileptics also constitute about 5 per cent of any mental-hospital population and an even greater proportion in hospitals in which special provisions are made for them. Their irritability, their tendency to get into fights, the injuries that they sustain from seizures, the erotic tendencies among the women, all are problems that complicate the administration of such a ward or service. There is more to this illness than the convulsive seizures, and the beginner should not be allowed to settle into the smug satisfaction of saying, "Oh, he's an epileptic. I saw him in a fit." To name, classify, and forget is the great bane of institutional psychiatry. The fit should serve only as a starting point for investigation. The term "idiopathic" should always arouse one's curiosity in whatever connection it is found. Sufficient contact with epileptics will serve to bring out personality traits that, while not entirely characteristic, are sufficiently striking to be studied.

Laboratory and X-ray Service.—It is to be assumed that the laboratory is in charge of a qualified pathologist who knows at least the rudiments of neuropathology. Deficiencies in this can be made up by a suitable consultation service, which the university could supply for an exchange of material not always available to it. The trainee should be taught to do complete autopsies and to write his own reports under the supervision of the pathologist. He should follow this up with the selection of blocks for microscopic study and should familiarize himself with the preparation, cutting, and staining of them. He can then do the microscopic study with the assistance of the pathologist. He should learn the various types of stain, be able to recognize them, and know what structures they are intended to visualize. During his stay on this service, he should also learn the various types of serology, with their interpretations, and the routine and special studies on spinal fluid. He should refresh his memory on general clinical laboratory methods, with special attention to the examinations commonly practiced in neurology and psychiatry, such as bromide and barbiturate determinations, end products of altered muscle metabolism,

and such new tests as may arise. The laboratory should serve as a center for practical work in neuroanatomy, neurophysiology, and neuropathology.

If the X-ray department is separate from the laboratory, then the trainee in the laboratory should be on call for X-ray work, where he can learn the techniques of examination, the interpretation of films, and the performance of encephalograms, lipoidal injections, and other specialized procedures. These he should ultimately be able to do for himself. The diagnostic spinal punctures he will perform under supervision as part of his laboratory duties.

Staff, Diagnostic, and Clinico-Pathologic Conferences.—Attendance at staff conferences should be obligatory, and in the smaller diagnostic conference the beginner should be encouraged to express opinions, however far they may be from the mark. He will soon profit by his mistakes and learn to avoid pitfalls in diagnosis and clinical evaluation. Because of the informality of these conferences, a more liberal discussion is possible, and older staff members should amplify their opinions by giving reasons and the methods by which they have reached this or that conclusion. This habit of thinking out loud is of definite value to the beginner by giving him leads which serve as starting points for investigations on his part. Here as nowhere else can he see the proper approach to interrogations of the patient without embarrassment to any one, and observe the subtle probing for desired information without pain to the subject. He sees here an art that is to be acquired only by broad experience and a thorough knowledge of people, their personalities, and their afflictions. Such conferences should point to definite collateral reading and, if possible, assignments should be made prior to the conference, which will then serve as a clinical demonstration of the material covered. If time is a factor, it is advisable to select cases for presentation instead of hurrying through a large number, with limited discussion and little interest other than to get them over with as quickly as possible. Stress should be laid on an understanding of the patient's problem rather than on a statistical diagnosis.

The general staff conference is usually somewhat different, since in most instances it deals with problems of administration, and medico-legal affairs such as competency, the

advisability of releasing previously dangerous patients, and so on. Here the beginner should be a visitor and should not be asked to express an opinion unless he has had immediate contact with the case under discussion and might contribute to an uncertain decision. He can, however, learn the special approaches and forms of interrogation appropriate to the various problems to be solved. He can gain some insight into the responsibilities of the hospital and how it protects the patients' and its own interests. He will see honest differences of opinion among members of the staff and will realize that such differences may exist in expert testimony without necessarily involving monetary motives. Such differences of opinion are stimulating; a conference with a chorus of "I agree" is deadly.

Clinico-pathologic conferences, as their name implies, constitute a post-mortem check on clinical findings, diagnoses, and treatment. Out of them should come added knowledge, from a realization of what mistakes have been made, how these may have come about, and how one may profit by them in the future. They can also serve to show the regression of pathology in cases of paresis treated by malaria, and the changes brought about by other treatments in other conditions. Through them the beginner is in continual contact with pathology throughout the training period, aside from the three months spent in the laboratory.

As a stimulus to better medicine and a protection to the hospital, all deaths that occur should be reviewed from the standpoint of the examinations made, the diagnoses, and the treatment carried out. This should not be a perfunctory review, but a very candid one, sparing the feelings of none, and directed to the elimination of mistakes by constructive criticism. We cannot expect to train any one in a hypocritical atmosphere of slipshod medicine. One who cannot subject himself to self-criticism or keep an open mind to constructive suggestions from fellow staff members has no place in a set-up for training beginners. We cannot be perfect, but we can be honest. The standards of the institution must be above reproach.

Mental-hygiene Clinic (or Clinics).—This clinic should be separate from any conducted at the hospital and should be

in charge of a qualified psychiatrist specially trained in extramural psychiatry. An inexpert staff physician who is willing to take on this service in addition to his ward duties will not do. It should be a full-time assignment. It need not be run by the hospital, so long as it is available to physicians in training and represents a coöperative endeavor. Aside from the director, it should be adequately staffed by a psychologist, social workers, and other necessary personnel. It should attempt to meet the needs of the community served by the hospital, or at least should contribute its share toward meeting these needs.

Physicians in training could be supplied in groups, depending upon the size of the classes and the needs of the clinic. It would be well in the work-up of their cases (under supervision) to have them go around with the social worker for a time in order to get a better appreciation of her work and the important part she plays in handling the situation. This would also give the beginner some opportunity to develop the art of sensing frictions and discordances in the home. The importance of basic training in adult psychiatry and the technique of dealing with parents should be stressed. There should be collaboration between the work of the clinic and that of the hospital, with the aim of illustrating prevention in the light of the abnormal end results found in the hospital.

In connection with the clinic, the beginner might be encouraged to give standard talks to community groups as an educational procedure in mental hygiene and, for his own benefit, as practice in public speaking. In its work amongst the poorer classes the clinic introduces the beginner to the social and economic aspects of psychiatry and in fact of medicine as a whole, unless he has previously been in general practice. The many elements that enter into a given problem are not only instructive in themselves, but in many instances are based on social situations beyond the control of the psychiatrist or even of the community. A thoroughly aroused interest in these is prophylaxis against institutional isolation.

Miscellaneous Instruction.—In keeping with the plan of orienting the physician to hospital problems, certain topics not included in those outlined above need to be explained to

the point of general understanding. Talks on hospital administration, preferably by the superintendent, illustrating the internal factors of organization and the functions of the various elements in furthering the hospital objectives, with particular reference to the interrelationship of the medical staff and the other units of the organization, serve to orient the beginner to his place in this scheme. Further talks could be devoted to the duties of the hospital to the patient, to his relatives, and to the community. The superintendent could add to the beginner's understanding by discussion of the particular problems of hospital administration and the ways in which members of the staff can contribute toward their solution.

The beginner could be assisted in part by practical talks from his department heads concerning their special problems and how they fit in with the general management of the institution. Every change in routine or innovation in some way affects nearly all the utilities in the hospital, and the physician should have a clear realization of how his moves are reflected in other departments. The matter of drug orders and the substitution of drugs to fit the pharmacy stock is one that might be mentioned specifically. There must be a policy concerning drugs, and because of the quantities purchased, impromptu changes cannot be made without loss.

Physicians who are to fit into the hospital scheme should have some idea as to budgets and budget making and should appreciate cost distributions and the peculiar financial structure that characterizes governmental agencies. Too little confidence is placed in the average staff by the superintendent when it comes to hospital finances. Certainly those in key positions on the staff should have some idea as to how their activities are limited by budgetary items. A staff so informed is more capable of intelligent coöperation, and blind following should not be expected of intelligent people. Talks on this subject could be given by the business manager and his assistants, and should tend to relieve some of the strain of his duties.

As part of this understanding of the hospital's inner workings, talks by the dietitian are in order. She assists in spending a large part of the hospital appropriation, and

any percentage of saving in her department is reflected in many dollars. The practical aspects of meal planning, purchasing, seasonal variations in prices, food costs, methods of saving, and the cost of special diets should be considered. The administrative details of the dietetic department as they relate to the medical staff should be explained and methods of smooth coöperation suggested.

In addition to the above, speakers on special problems relating to clinical and administrative topics should be scheduled, in a further effort to broaden contacts. Seminars on various subjects can be conducted by experienced individuals at first, the beginner later being given an opportunity to handle the various elements of such a group.

As part of the general instruction, collateral reading in connection with set courses and special cases should be assigned. This should be separate from the assignment of magazine articles and books for review. Reviews should be prepared for presentation to the rest of the staff and made the subject of discussion.

Every physician should have some experience in compiling standard statistical tables not only that he may be familiar with them, but that he may appreciate the necessity of accurately filling out statistical cards. This for the most part is a neglected job and its importance is realized only after one has tried to compile tables from cards poorly made out.

So far we have drafted only a brief résumé of the possible utilization of set hospital functions in the training of the psychiatrist. To be added to these is a schedule of didactic instruction which, even if it does not exist, is properly part of a hospital's duties. Courses of instruction can be arranged without much interference with the care of patients and given by members of the staff. Broader aspects and applications can be obtained from speakers on special topics, and there should be constant practical application of the principles taught to the everyday clinical material. This creates an atmosphere of constant questioning, of seeking for dynamics, and offers an opportunity for clearing up lecture points, clear in their presentation, but obscure in their application.

The courses offered should be those prescribed by the

American Board of Psychiatry and Neurology, for the details of which I refer to the syllabus put out by the board. In general these courses include (1) neuroanatomy and neurophysiology; (2) neuropathology and roentgenology; (3) psychobiology; (4) psychopathology; (5) clinical neurology; and (6) clinical psychiatry. The natural place for conducting the courses in the first two is the laboratory, where there should be ample material for teaching. For neuropathology an exchange of material with the university pathologist and a properly set up museum will afford a range of specimens of disease that will cover the whole field. The teaching of the last four courses should be illustrated by case material and demonstrations by clinics. The state hospital will offer an ample number of patients for demonstrating neurological signs and the more common neurological conditions, but for the infections and other acute neurological problems, it will be necessary to make use of affiliated services.

In addition to these courses, there should be at least some orienting lectures on mental hygiene and social work, as stress should be placed on the sociologic and economic aspects of psychiatry. Some will be especially interested in this phase and will follow it further, while others will keep more closely to the medical aspect of the subject. There should be no thought of sub-specialization, however, until the general groundwork has been laid.

The elements of psychotherapy can be given in connection with the course in psychobiology and as part of the study of the phases of personality development that one sees in the mental-hygiene clinic. The technical details of psychotherapy had best be given in connection with clinical material. The beginner should be given practical pointers on procedures and the cautions to be observed. It is to be assumed that in his course in psychobiology, he has gained some insight into his own traits and tendencies and that he can begin to make allowance for these in his professional relations with patients. Constant consultation with the psychotherapist and some restraint on the beginner's enthusiasm will prevent discomfort both for the patient and the administration. They are very necessary for a proper start in what might be called one of the artistic phases of psychiatry.

There should also be a brief review of the fundamentals of biochemistry, with particular reference to more recent advances, such as those in muscle, protein, and carbohydrate metabolism. Metabolic disturbances, vitamins, and the changes in physiological functions incidental to endocrine disorders might also be included. The types of test and their interpretation can be given here and their technique learned in connection with the laboratory assignment. Psychiatry must take some notice of the rarer, more obscure problems of internal medicine. Any number of such cases reach the state hospital and the psychiatrist in private practice, having baffled the diagnostic skill of their own physicians. This is due in part to the obscurity of these conditions and in part to the inability of physicians to evaluate properly psychiatric symptomatology. This situation will in time be corrected through undergraduate teaching of the subject, but it must be recognized while it exists. Constant reference to laboratory tests and to biochemical principles in connection with clinical studies will lay proper stress upon them as they relate to these conditions and to the field of psychiatry. Even if capable consultants are available, they will be useless unless such disordered functions are suspected by the ward physician.

Lastly, it should be insisted that the physician in training understand the pharmacology of any drug or preparation he prescribes. There is too much ignorant prescribing for the mentally ill, particularly of sedatives, vitamins, endocrine products, and new preparations as they appear on the market. One has only to study the shelves of the hospital pharmacy to read the history of drug therapy in the psychoses, and to see the remains of passing fancies. Certain drugs are empirically useful, but as a general rule an understanding of the principle of the action of a drug and of the function it is to perform in a given instance is necessary for rational therapy.

I have given a preliminary outline of the way in which the state hospital can function in training psychatrists. Despite the difficulties that these institutions face, I am convinced that such a program is possible in enough of them to furnish capable workers in this field. They have in the

past supplied men with a broad background upon which successful and outstanding careers have been built. A great many of these men left the institutions for private practice and the teaching field, and of those who remained most have graduated into administrative positions in which their contacts with patients and clinical problems have receded into the background. Their abilities have been devoted to building up their institutions and securing sufficient funds for their maintenance. It is to be hoped that in a program for building up properly trained psychiatrists, some attention will be given to more comfortable quarters, better living conditions, better pay, and more opportunities for postgraduate instruction for those on the staff engaged in the clinical field. Unless this is done, the outstanding men will continue to be attracted to the administrative field and to private practice, leaving the less capable and the younger men in actual contact with the patients.

The great bulk of material for psychiatric study and research is on the wards of the state hospitals, and any proper utilization of this material will depend upon the ability, the clinical acumen, the training, and the curiosity of the men who see these patients day after day. Problems of research should grow out of these daily contacts and the observations based upon them. I recently congratulated a newly appointed director of research upon his opportunities, and his reply was that it was limited because the men on the wards would send him no problems. Good psychiatrists, properly oriented and serving on the wards, can correct this difficulty and contribute to further advances in the field. This is a recognized need and the most important step in psychiatry is to see that it is filled.

Out of such a group it is to be expected that the undergraduate teaching field can be supplied. It cries out for capable men at the present time. We should, therefore, attend to the organization of such centers as speedily as possible and by proper inspection and certification, insure the maintenance of standards of instruction. The graduate of such a course, imbued with the proper spirit, can build upon this basic training and be an influence for betterment wherever he may choose to go.

COLLEGE MENTAL HYGIENE—A DECADE OF GROWTH

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NUMEROUS writers have, in recent years, indicated that there is serious need for more attention to the mental hygiene of college students. Studies of courses in mental hygiene in colleges have been made from time to time. These studies have not, however, furnished a clue to the rate of growth of mental-hygiene instruction in American colleges and universities. The study reported in this article was made to throw light upon this matter of growth. Specifically, it was an attempt to answer the question: What changes have taken place in the provision of mental-hygiene courses in colleges over a ten-year period?

In order to answer the question, a number of catalogues, of 1939–1940 issue, were examined to see whether or not courses in mental hygiene were offered. The offerings of 1939–1940 were then compared with those listed in 1929–1930 catalogues. It was felt that from a comparison of the two sets of data some tentative conclusions regarding the extent and growth of courses in mental hygiene in American colleges might logically be made. It was arbitrarily decided that 75 colleges that were currently offering such courses would constitute a sufficiently large sample. This decision is warranted in the light of other studies dealing with a similar problem.[1]

The desired sample of 75 courses was found from an examination of a total of 178 catalogues. That is, 42 per cent of the colleges whose catalogues were studied offer work that is specifically described as having as its major function the study of mental hygiene.

The fact that if this sample can be taken as a criterion, mental-hygiene courses are offered in almost half of our

[1] See, for example, "Mental Hygiene in American Colleges and Universities," by Theophile Raphael, M.D., Mary A. Gordon, and Emma M. Dawson. MENTAL HYGIENE, Vol. 22, pp. 221–36, April, 1938.

American colleges might be regarded as somewhat encouraging, especially in view of the fact that the organized mental-hygiene movement is relatively young. To those who believe firmly in the value of mental hygiene, however, it is distinctly discouraging that less than half of the students attending college have no opportunity for studying mental hygiene in an organized course. It seems that there is still much to hope for in the way of provision for the direct study of mental hygiene by the college student.

The outlook is less bleak, however, when these findings are compared with the status of mental hygiene ten years ago. The 1929–1930 catalogue of each of the 75 schools that listed a mental-hygiene course in 1939–1940 was examined to see if such a course had been offered ten years ago. Only 28 schools —37 per cent—from the sample of 75 were at that time listing and describing such work. In other words, courses in mental hygiene have almost trebled in the decade from 1929 to 1939. This evidence offers more encouragement than does the study of present-day offerings alone. Evidently the efforts of those who have sought to encourage the study of mental hygiene are being rewarded, and it seems highly probable that, with attention being called to the matter from many angles, future growth will be at least as rapid.

Validity of the Sample.—The 1938 Educational Directory of the United States Office of Education lists slightly over 650 American colleges and universities. The sample of 178 used in this study, then, represents about 27 per cent of the total number. This sample seems to be adequate as regards enrollment—that is, the colleges studied had an average enrollment that was close to the average of all colleges listed in the Educational Directory. The average enrollment of all the schools studied was below the average enrollment of the schools that offer mental-hygiene courses and above the average enrollment of the schools that do not offer such courses; also above the average enrollment of all the schools listed in the 1939 *World Almanac*. These averages are as follows:

Average enrollment of the 75 schools that offer courses in mental hygiene	3,559
Average enrollment of the 103 schools that do not offer such courses	1,939
Average enrollment of all schools (1939 *World Almanac*)	2,042
Average enrollment of schools studied	2,860

It is probable that the catalogues of the smaller institutions are not so regularly filed in the library at the University of Oregon, where this study was made, as are those of the larger schools. Nevertheless, it is apparent that the larger schools more frequently offer courses in mental hygiene than do the smaller ones. Probably the smaller schools do not think less highly of mental-hygiene courses, but their staff members have less time to carry on this significant work.

Course Titles.—The titles of most of the courses indicate clearly that the problems of mental hygiene and mental health are dealt with. The various titles and the frequency with which they appear are shown in the following list:

Title of course	*Number of appearances*
Mental Hygiene	39
Abnormal Mind, Abnormal Psychology, and Mental Hygiene	7
Psychology: of Adjustment, of Personal Adjustment, of Personality	7
Mental Hygiene: of the School Child, of the Adolescent, in Teaching	5
Personality Adjustment and Mental Hygiene	4
Principles of Mental Hygiene	3
Human Personality, Personality Maladjustment	2
Mental Health	2
Problems of Life, Hygiene, Psychotherapy and Mental Hygiene, Mental Hygiene and Industrial Arts, Mental Hygiene and Social Work, Educational Psychology and Mental Hygiene (one each)	6
Total	75

Many other courses dealing with abnormal psychology besides those mentioned above were listed in the catalogues. They were not classed as courses in mental hygiene, however, unless it was specifically stated that a major part of the course dealt with the problems of mental hygiene. In many cases, the description of a course called "Abnormal Psychology" was quite similar to that of a course called "Mental Hygiene," except for the fact that mental hygiene as a major emphasis was not mentioned in the course designated "Abnormal."

Departments Offering Mental-Hygiene Courses. — The majority of the mental-hygiene courses are offered in the psychology departments of the colleges. Most of the remainder of the courses were listed under education. Some

were given jointly by the psychology and the education departments. Specifically, the data on this point were as follows:

Department offering course	*Number of instances*
Department of psychology	50
Department of education	17
Departments of education and psychology, jointly	4
Departments of education, physical education, and psychology, jointly	1
School for social workers	1
School of medicine	1
School of physical education	1
Total	75

Availability of Courses.—It is evident that mental hygiene is conceived as something to be applied to some one else—that is, the student's own individual need for mental hygiene is largely neglected. Relatively few courses, only six of the 75, are for lower-class students and have as one of their major emphases the matter of adjustment to college life. There are other lower-class courses in mental hygiene, but they are professional in nature. Most of the courses are for upper-class students and are designed for those who will at some time in the future have some influence over the lives of other people. The following list indicates the distribution of courses as to collegiate level:

Course available	*Number of instances*
To upper-class students	57
To lower-class students	13
To graduate students	4
To both lower- and upper-class students	1
Total	75

Nature of Courses.—The catalogue description is an inadequate indication of the nature of a course. In some catalogues there is no description at all, while in others the description runs to ten or twelve lines. It would be grossly unfair to judge one course as more adequate than another by the number of topics listed in the discription. However, an idea of the general nature of these mental-hygiene courses can be gained from the following tabulation, which indicates the topics dealt

with and the frequency with which they are mentioned in the description:

Topics	*Times mentioned*
Personality development and personal adjustment	43
Discussion of the needs of prospective teachers	26
The preventive aspects of mental hygiene	25
Problems of the normal individual	25
Social adjustment	18
Institutional and individual case studies	18
The abnormal individual	17
The establishment of habits and attitudes	10
Common escape mechanisms	7
Collegiate adjustment	6
Parental problems in mental hygiene	6
Problems of social workers	5
Problems of doctors, lawyers, nurses, and psychologists	4

SUMMARY

The study reported here, in which a sample technique was employed, indicates that approximately 42 per cent of American colleges and universities offer courses in mental hygiene. This agrees substantially with the findings of Dr. Theophile Raphael and others, who have reported that a questionnaire sent to 835 American collegiate institutions (including teachers colleges) shows that 30.9 per cent of the small, 41.4 per cent of the medium, and 51.9 per cent of the large institutions provide "courses in mental hygiene as such."[1] Their findings point to the validity of the sample used in this study, as regards present status, and may stimulate credence in the second major conclusion that this study makes possible—namely, that mental-hygiene courses have nearly tripled in the past ten years.

The study seems to warrant also the following conclusions:

Mental-hygiene courses are offered more frequently in large schools than in schools with smaller enrollments.

The majority of the courses are offered in the psychology department, with the education department an infrequent second.

Most of the courses are designed for people who will at some time have a degree of control over the lives of other people—teachers, parents, and psychologists.

Personality development and personal adjustment are the

[1] Raphael, Gordon, and Dawson, *op. cit.* p. 226.

topics most commonly treated, and the emphasis is upon the prevention of mental ill health in the lives of normal individuals.

The title most commonly used for these courses is "Mental Hygiene."

While the number of mental-hygiene courses at present offered may not be highly encouraging, the rate of growth does indicate that definite progress is taking place. The impetus that the mental-hygiene movement already has will, in all probability, become greater as mental-hygiene teachers and clinicians demonstrate the value of their work.

The fact that most of the courses are for prospective parents, teachers, and psychologists has both gratifying and disquieting aspects. On the one hand, it is gratifying to know that teachers are getting a chance to learn something about the mental-hygiene approach in education. Such training should make them teachers who are capable of furnishing a good emotional "climate" for their pupils. On the other hand, it is disquieting to find that the mental-hygiene requirements of college students, as individuals, are being rather largely neglected. Ten years ago Ernest R. Groves pointed out the vital need for mental hygiene in colleges because of the adjustment problems involved in college life. The factors that make for difficulty in this adjustment are as follows:

1. The student is obliged to spend a long period of time away from home.
2. The student is expected to be self-directing.
3. Competition and self-esteem are sources of much trouble.
4. The college environment forces rapid growth.
5. Problems of sex are disturbing (though not caused by campus life).[1]

The present study indicates that these problems are being almost totally ignored. The fact that the problem of collegiate adjustment is a serious one would seem to indicate that there might well be more than six courses out of 75 that deal specifically with these problems. There would seem to be rather definite need for more service courses in "Mental Hygiene" in American colleges and universities.

[1] "Mental Hygiene in the College and the University," by Ernest R. Groves. *Social Forces*, Vol. 8, pp. 37–50, September, 1929.

ALUMNI OPINIONS CONCERNING A HIGH-SCHOOL COURSE IN MENTAL HYGIENE *

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ALTHOUGH more and more schools are introducing courses variously entitled "Human Relations," "Social Relations," "Human Problems," "Personality Study," and so on, and student reactions to these courses have been favorable, not much in the way of scientific evidence has ever been presented to show that teaching these courses is really valuable. The object of this article is to offer a little such evidence in the form of the opinions of people now out of school who took a course in mental hygiene when they were in high school.

Two and a half years ago a course in mental hygiene (listed as "Human Relations") was offered to juniors and seniors in Alpena High School. It was described as a study of the mind and mental habits for the purpose of enabling the individual to develop and maintain mental health. Later, it was more simply defined as the study of getting along with one's self and with others. Discussions of the motivation of behavior consumed a large share of class time. Since September, 1937, eight groups have been enrolled in the course, and although there have been enough indications that a course such as this fills a need among boys and girls of high-school age, actual evidence of the fact had not been gathered until last summer when a questionnaire was sent to the members of the first class.

* EDITOR'S NOTE.—In presenting this report on the reactions of a group of former high-school students to a course in mental hygiene, we wish to point out the experimental nature of any such course at this time and the importance of preserving a questioning attitude toward it until further follow-up studies at longer intervals are available. We are aware that questions might be raised also with regard to the evaluation of the students' replies; a reply that some might class as favorable might by others be considered unfavorable. What the replies do clearly indicate, however, is youth's need for some sort of guidance in the field of personality adjustment.

The questionnaire was reasonably brief—thirteen questions in all—and was designed to secure an aggregate of student opinions that might help in the constant improving of the course. The questionnaire was also introduced in such a way as to encourage frankness: "All information will be kept in the strictest confidence, so I would appreciate thoughtful and frank answers, whether favorable or unfavorable." It was sent to members of the first group only, many of whom have been graduated since June, 1937, and all since June, 1938. Several members of the group are now married. Members of subsequent mental-hygiene groups will not receive questionnaires until a two-year interval has elapsed between their enrollment in the course and the filling out of the questionnaire. This lapse of time will, to some extent, insure not only maturity of opinion, but also greater sincerity of expression, for the relationship of teacher and student sometimes changes after graduation.

There were several reasons for sending out a questionnaire and gathering evidence of student reactions to their mental-hygiene course. One of these was simply that the teacher wished to know whether the psychiatrists were right. Before the first semester had begun, the teacher conferred with two psychiatrists on the plan of the subject matter, the techniques of teaching it, and the aims of the course. The psychiatrists discouraged him on the grounds that personality adjustment is an individual matter, that individual problems cannot be solved in a group, and that study of symptoms would probably lead to symptoms. If their fears were true, it was felt that it would be well to have the evidence and either correct the procedure, alter the subject matter, or eliminate the course entirely. Perhaps the people who had taken the course two years before in high school could express themselves. If their opinions bore out the prophesy of the psychiatrists, the course would have no excuse for being.

Another reason for gathering evidence of student reactions was that the teacher himself had from the first anticipated certain disadvantages in constructing a course in mental hygiene for high-school students and teaching it as a subject by itself, for he believed that ideally mental hygiene should pervade all teaching. Among the disadvantages, the following were mentioned: "(1) The course itself would be untried

and experimental; it would take some time to determine just what should be taught and what should not be taught. (2) Adjustment itself is a part of other activity, and teaching it in a course of mental hygiene would unavoidably isolate it more or less from real situations. (3) The course might have inherent defects, such as a tendency toward over-suggestion, emphasis upon sex, invidious comparisons, dominance of teacher personality, and other inherent defects."[1] With careful planning and foresight, it was thought, these disadvantages to some extent could be avoided, but it would still be desirable to know first-hand, from the students themselves, whether these shortcomings really had serious significance. The proof of the pudding would be in the eating.

Still another reason for gathering evidence from student reactions was a natural curiosity on the part of the teacher as to the effectiveness of the course. The questionnaire could be so designed as to secure information that quantitatively would provide at least a better measure than he had had before.

And, finally, replies to the questionnaire might suggest improvements for the course, in the way of teaching devices, additional subject matter, and corrections.

Before presenting the opinions of former students, a brief description of the course itself might well be given. Mental hygiene, a half-year, half-credit subject, was listed as an elective for juniors and seniors. The first class had an enrollment of 39 and was in all respects an average group, except that it exceeded by 12.9 the pupil-teacher ratio for the school. Every student had at least two conferences with the teacher, one at the beginning of the semester and one near the end, and all were free to come for additional conferences. During the first month each member of the group received unsigned, constructive criticisms from all his classmates. The instructor helped the student evaluate these criticisms in the initial personal conference.

During the second month, a mutual rating sheet was distributed. This sheet had the class enrollment and certain criteria for grading. Each student marked his classmates according to their social fitness. The sheets were then col-

[1] From "Mental Hygiene in the High School," by J. B. Geisel. *The Phi Delta Kappan*, Vol. 20, pp. 186–94, February, 1938.

lected and tabulated, and the totals were given to the students privately. The average, range, mode, high, and low figures were given to the group, so that each student could compare himself with the group as a whole. Names, however, were withheld.

From time to time the class meeting was taken over by other teachers and visiting speakers. As a text accompanying the course, J. J. B. Morgan's book, *Keeping A Sound Mind,* was used. This text, however, proved too difficult for many members of the group, and it has since been abandoned except as a supplementary book from which a number of important assignments are made. Notebooks were kept for recording principles as they grew out of discussions, for preserving clippings of special interest to the individual student, and for making choice selections from the text. A small bulletin board was used by the members of the group for the posting of any literature or illustrations that they thought were interesting and that had a bearing upon the subject.

The following outline will give an idea of the course:

I. Temporary definition.
II. Physiology of the nervous system.
III. Insight—attitudes for growth and rebuilding of personality.
IV. Master drives—a study of the temporary dominance of each drive.
V. Emotions—a study of each in relation to individual peace of mind.
VI. Emotional maturity and immaturity. Definition and illustrations.
VII. Social maturity and immaturity. Definition and illustrations.
VIII. Feelings of inferiority—origin, cause, and possible solutions.
IX. Introversion and extraversion—personality types and analyses.
X. The escape reaction and defense reaction.
XI. Specific ways of getting along with people and securing friends.
XII. Techniques of leadership.
XIII. Habits for developing and keeping mental health. This last unit was essentially of a summary nature, and notebooks were used for a review of principles gathered during the semester.

Emphasis throughout the course was upon the normal, not upon the abnormal. Principles were studied by continually relating them to the students' own experience and knowledge.

In addition to the text already mentioned, a few books were used a great deal for reference. Those most widely read by the students were Dale Carnegie's *How to Win Friends and Influence People; Strategy in Handling People,* by J. J. B. Morgan and L. T. Webb; H. A. Overstreet's *About Ourselves;* Percival M. Symonds' *Mental Hygiene of the School Child;*

and Milton Wright's *Getting Along With People.* The reading shelf has since been enlarged by a number of excellent books, of later publication dates, more especially written for adolescents. Perhaps it is safe to say that few, if any, books in the field of adjustment education, written for the adolescent reader, have been off the press more than three years.

Here, then, is a brief description of the course as originally given in 1937. More detailed information would perhaps be unnecessary for the purposes of the present article. Since the time of the first experiment the course has undergone various additions and changes, affecting choice of text and subject matter, use of pupil-teacher conferences, teaching devices, and bibliography. Discussion of these changes would have to be included in a detailed description of the course, for they indicate corrections, improvements, and further experimentations. It is important to mention here that the pupil opinions presented have special reference to the course in which they themselves were enrolled, the course briefly described above.

Because of a change of address, it was impossible to get in touch with one member of the class. The other 38 all replied to the questionnaire. In most instances, their opinions will be quoted verbatim.

The first question, "Do you think Mental Hygiene, as the study of getting along with one's self and with others, is a good course for high-school seniors?" was answered in the affirmative by all of the 38. Reasons for answering thus were also given, the most common being that the course was a help in future life—in college, in holding a job, in marriage, and so on. Sixteen students made such answers. Nine students said that it had given them a better understanding of other people, and nine that it had helped them to become conscious of their own faults and to improve. Three said that the course had opened a new field of knowledge for them. One made no comment.

The second question, "Do you understand any of the principles studied in the course better now than you did two years ago?" was answered in the affirmative by 33 of the 38. Among the affirmative comments given, the most common was that the principles learned in the course now had a deeper meaning and were more clearly understood because of life experiences during the two-year interval. Twenty-five made this com-

ment. Two said that further study had made the principles clearer. Six who answered in the affirmative made no comment. A few of the affirmative comments are quoted here:

"In some cases I have tried different principles to see if they were so, and in most cases I found they were."

"I can understand people's reasons for doing things."

"I'm more able to see behind other people's emotions and see their motives and reasons."

"Face the facts. I think I know how to apply rather well."

"Defense mechanism! I think at times I excused myself for many things unjustifiably."

Five students answered this second question in the negative, one making no comment. The comments of the other four were as follows:

"No, but now I can see where they are very useful, which is something I didn't before."

"No. Not enough emphasis was put on all of the course. Should be longer."

"Not a lot."

"No, the principles were not thoroughly studied and taught, and I couldn't grasp the full meaning."

The third question, "Do you think the course will help you in the future?" was answered in the affirmative by 36. One response was negative, and one "could not answer." Of the affirmative comments made, the most common was that the principles learned in the course would be of help in understanding and getting along with others. Twenty-one made this comment. Four stated that the principles learned would be of help in their careers, and five others said that these principles would help them in their own personality adjustments. Six made no comment.

The fourth question, "Has the course actually helped you in your relations with other people?" was answered in the affirmative by 37. One response was negative, and one of the affirmative responses was given without comment. Among those who gave affirmative replies, 17 said that the course had actually helped them to understand other people better; four stated that it had helped them overcome self-consciousness; and two said that it had helped them control their tempers. Other reasons given are quoted here because they are specific and interesting:

"I'm a good listener, and I can carry on conversation much easier."

"I treat the people better than I did before and got away from bad habits."

"I made friends easier while in college than while I was in high school."

"I learned that you can't always have your own way. It is a matter of coöperation."

"How to contact and how to make myself appeal to them."

"Now I get along much better with my family."

"Because of better understanding, I have been able to meet people and sell and interview better."

"There was one person whom I couldn't get along with at all, so I said to myself, 'Study why she does things in that manner and attitude,' which I did. I can see now why she did it and I had a talk with her, and we are good friends."

"I have understood different moods."

"I've learned to be contented with what I have and instead of making others miserable beefing about what I hadn't, I've gone out and gotten or worked for what I wanted."

"In my work, and with my family and friends."

"It made it easier for me to make friends."

"People don't seem to find me so unapproachable."

"It has helped me in my efforts to be a good wife."

The fifth question, "Has it helped you in understanding and improving yourself?" was answered in the affirmative by 36 of the 38 who responded. One response was negative, and one was hard to classify: "The older I get, the less I seem to know of the principles." Two of those who responded affirmatively made no comment. Among the affirmative statements the most common was that the course had helped the students to practice more self-control. Twelve made this comment. Eight stated that the course had helped them in eliminating faults and in being more likable; three, that it had helped them to overcome self-consciousness and inferiority feelings; and two, that it had helped them to understand themselves better. Other opinions were as follows:

"Written criticisms told me what to do to improve."

"There were two subjects I wish we might have devoted more time to—sex and leadership. I particularly liked the assignment on self-analysis."

"I can meet people and be friendly with them. Before I was on the defensive side."

"Aided in discarding infantilisms, presented many ideas."

"I am very self-conscious about my walk, and this has always been a great difficulty to me. Now, when I walk in front of a group of people, I begin to think of this and I force this thought out of my mind and think of something pleasant or something I like and I seem to walk much better."

"I do not sit back and let others do things."

"I follow an idea through."

"I understand my different moods and try to prevent the bad ones. This has helped very much, because I can understand my husband's mood also and it has prevented many quarrels."

"I have sort of adopted Dale Carnegie's principle to 'listen.' I have made more friends by listening than by talking."

The sixth question, "Is the information which you gathered at the time of the course still helping you to-day?" was answered in the affirmative by 33 of those who responded. Three responded in the negative. Two did not answer. Seven of those who responded affirmatively made no further comment. The responses were brief and sincere:

"Mentioned above."

"Can diagnose my actions and thoughts."

"It still helps me to broaden my personality."

"I read my notes and parts in my books."

"I make new friends every day."

"By treating others the same way as myself."

"Knowing that people have troubles the same as we."

"It is helping me now in dealing justly with other people—to understand their desires and to consider them."

"Things I remember naturally affect decisions I make and attitudes I take toward things."

"With every contact."

"In controlling temper and losing inferiority complex."

"Because of better understanding, I have been able to meet people, interview better, and sell better."

"In analyzing my own and others' behavior."

"I've learned to face the tough things and to see the other person's side."

"Able to read deeper subjects."

"I no longer have an inferior feeling when talking to folks."

"In a general way, I suppose."

"In getting along with fellow students."

"That information will always hold true."

"By going more than halfway to be friendly."

"In studying characterizations of people I see."

"By using author's confirmed statements and trying to put them into practice."

"Helping me in my relations with business men."

"Meeting people.

"It has helped me in my efforts to be a good wife."

"Getting along with people—control of emotions."

The seventh question, "Mention any specific techniques, habits, or ways of doing things which you learned during the course and still use in daily life," was not answered by

eight students. The replies of the 30 who did answer were as follows:

"Can't think of any now, but am sure there are a number."

"Try to figure out why some person does or did a specific thing and why he is like that."

"Try to get at the heart of each new problem I meet."

"Learning to control my temper and influencing other people."

"I am more helpful and I do my work and play afterward, and I try to keep smiling."

"Kindness, simplicity, love, honesty, happiness, sincerity, truthfulness."

"Be a good sincere listener. Consider the other person's point of view."

"Forcing myself to do something I fear; analyzing people I think are conceited."

"Perseverance overcomes everything."

"Approaching people, understanding people, and understanding and correcting myself."

"Do not shout at people. Many of my habits remain much the same. The course has not affected them."

"By trying to find a motive for things I and my associates do."

"By being cheerful and trying to understand people."

"When I am working on something which I dislike and can't seem to get it done, I quit and do something directly the opposite or something that will take my mind off this task. Then I return to my unpleasant task and I seem to be able to do it much better and ever so much faster than before."

"Breathing deeply if I can't go to sleep. Learned never to turn back or hesitate if there is something I dread doing."

"Know thyself and face the facts."

"I don't try and fluster any more."

"My criticisms said that I was always smiling, and I try to do that more than ever now."

"None that I can think of."

"To sit back and listen to other people, and in that way learn to understand them."

"When I meet people, I don't judge them until I know them better."

"None."

"I still use the Fear-Fight-Victory habit." (Two gave this answer.)

"I'm more outspoken and frank with everybody."

"Habit of following a thought through as well as I can."

"I think I am a little more methodical and a lot more pleasing to people who are my friends and the general public as a whole. My future demands it, so I have to do it."

"It helped me not to make trouble with any one who bothered me."

"Sometimes, if anything is bothering me, I sit down and write my trouble in form of a letter to my mother. Then I read it over once and tear it up. I always feel better, too. I've learned to keep busy doing useful things when my daily work is done."

"One that helps me most is that I have learned to receive a criticism and try to correct fault."

The next question, "In which respects did the course fall short?" was answered by 34 of the 38. Four made no comment. Eleven of the 34 thought that the course should be longer. Six said that they could suggest no improvements. Three suggested having more outside speakers. Three thought that more time might be spent on boy-and-girl relationships, and three, that more time might be given to self-analysis. Other comments are as follows:

> "Did not deal enough with coöperation tolerance."
>
> "Not enough personal discussion—students' problems."
>
> "I frankly think that the course was quite complete except—I think now that if we would have had some reports or topics given before the class it would be a great help. As a general rule, students do not feel at ease before a class and in a class of that sort, where they all talk freely and frankly, a student could get over his self-consciousness."
>
> "I wonder if a week or so could be spent on manners. There are books in the library that would do some a lot of good."
>
> "The name of Mental Hygiene is much better than Human Relations."
>
> "Not emphasis."
>
> "Not enough outside work. We should have reported on personalities daily."
>
> "I don't think there could ever be too much oral work in class."

One girl said that the course fell short in that a certain pamphlet, *Growing Up In the World To-day,* by Emily V. Clapp, was included in the reading matter. She argued that the course was in mental hygiene, not "body hygiene," and therefore should not include information on sex. The pamphlets had been distributed at the beginning of a period and collected at the close of that period. The instructor did not discuss sex questions during the semester, for he doubted the wisdom of doing so. This pamphlet was not discussed at all in class, although members of the group knew that they could go to the instructor for a further conference if they so desired. The same girl who disapproved of the reading matter mentioned here, however, was one of those who responded most enthusiastically to the questionnaire.

It is also worth mentioning in this connection that the one questionnaire not yet returned is in the hands of another girl who disapproved of the use of this same reading matter. This girl, born in a small European country and reared in a very much inhibited home environment, may have been shocked by the information contained in the pamphlet. Information as to the reactions of these two students did not come

to the instructor until after the questionnaire had been distributed. In fact, he had had satisfactory conferences with both of these students during the semester.

Perhaps it is not logical to conclude from these two instances that reading matter such as *Growing Up In the World To-day* should be eliminated from classroom study, and yet it seems prudent to do so. Mental hygiene in high-school classes is a sort of group guidance and cannot be taught as individual, personal guidance.

One boy said that the course fell short "in the presentation." His responses to the questionnaire were entirely negative except that he did express himself favorably on the first question. The fact that his responses alone were essentially negative was a matter of concern to the instructor. Accordingly, he visited the boy to discuss the matter in person with him and learned that the semester grade given was not considered satisfactory and also that the boy had from the first resented being enrolled in the course. Actually his mother had arranged the matter, a fact that the boy did not know until the time of the instructor's visit. Instead of either dropping the course or discussing his feelings, he had remained in it, silently resentful throughout the semester. Needless to say, the visit of the instructor ended in a reversal of the boy's attitude.

To the ninth question, "Were there any topics, not treated in the course, which you wished to know more about?" 11 made no response. Fourteen said that there were none. Six would have liked to know more about the brain, its functions, mental disorders, and so forth; and two would have liked to know more about sex. One replied "yes," but did not specify further. Other comments were:

> "There are millions of topics in this world of to-day."
> "All topics were vague due to lack of time."
> "Self-control should be especially stressed. Try to convey the idea of having an open mind and not keep everything to oneself."
> "Reasons for friction among groups, races, etc."

In answer to the tenth question, "What suggestions, if any, would you make for the improvement of the course?" eight suggested more activities for students. Five recommended a longer course, three suggested having more outside speakers,

and two thought that the class should be more informal. Eight made no comment. Other comments were:

"Review more often so students could remember more."

"Use only one textbook to study carefully, and special lectures and reports for other subjects."

"Why not analyze newspaper clippings and trace out why this or that happened?"

"Study the topic of 'inferiority complex.' Means much in getting along with people."

"The only suggestion that I could offer for improving this course would be to have two-period classes. Many times we were in the midst of a very interesting discussion and had to quit because the bell rang and then the next day we either lost interest in the discussion or didn't have time to go through it thoroughly. Therefore, I think two-period classes would greatly improve this course."

"I believe we spent a little too much time on the various drives. I don't seem to be able to remember much about them for all the time spent on them."

"Try and find faults about you and your companions."

"A study of marriage, most suitable age, and what to expect of each other."

"A deeper meaning of the principles required to learn."

"I haven't any."

"My suggestion would be that the people in class would not be mixed group like that class I was in. I realize that in a way it takes lots of personalities to make a class interesting, but, if it were to help a student in improving himself, he can't feel abashed, inferior, or ashamed of his opinion in comparison with opinions of many who talk just for the love of talking (having center of stage) or who misrepresent in the hope of making an impression."

"Less lecture by instructor, more book work and development of course by students."

The eleventh question, "Has the knowledge gained created new problems for you?" was, to judge by the responses, an ambiguous one. Twenty-one students responded in the negative, five gave no response, and those who answered in the affirmative added explanatory comments, as follows:

"In a way. My actions now demand an answer or a remedy."

"I study people and look into their background. That way you learn their likes and dislikes."

"Problems to get along with others and ways to solve my own problems."

"It showed me that I am every bit as good as the next fellow."

"It left some questions undecided in my mind."

"I have tried not to be a hindrance."

"A desire to learn more, morally, spiritually, and mentally."

"I'm afraid I've become too assertive."

"I have been told I have become too conceited and too self-confident for the amount of 'gray matter' I possess."

"I can see the faults and trends of thoughts of others easier."
"In a way, I think it has."
"It makes me wonder if there is any hope for myself."

The instructor, during a short visit with the young man who gave the last response quoted, was able to help him understand his problem, continue his constructive efforts, and bolster up his hopefulness. As a matter of fact, he is a promising young man, holding a good position, in which he has for two years shown fine intelligence and dependability.

Twenty-five answered affirmatively to the twelfth question, "Has this course influenced your study or reading? If so, can you mention courses of study or titles of books, magazines, and articles?" Eight answered in the negative, and five did not answer. Some stated that they had read articles on psychology and human relations in the following magazines: *Ladies' Home Journal, Mercury, Readers' Digest, Life, Look,* and *Liberty.* The following titles of books were listed by others: *The Human Mind, How to Win Friends and Influence People, Will to Power, Business Power,* and *A New Personality.*

Some of the responses to the thirteenth question, "Can you mention any specific troubles or difficulties which you solved with the help of information gained in Mental Hygiene?" may be summarized as follows: seven students said that the information definitely had helped them get along better with others; six, that the course had helped them to overcome self-consciousness; and three, that it had helped them to overcome an inferiority complex. Other comments were as follows:

"I analyzed my homesickness at college and ended up by laughing."
"It has helped me solve my own personality problem."
"I talk louder and express my opinion and am not shy."
"How to control my temper."
"Found out the why of different reactions under different circumstances."
"The greatest problem I had, that of self-control, and the loss of many childish habits."
"I was terribly nervous and at times when I was very tired I had a hard time controlling myself, although no one knew it, but even before I had finished the course I overcame this fear. The phrase, fear-fight-victory, helped me immensely at this time. I believe that phrase was the most important one I learned in the course. I think I said it a million times that year and it never failed once. I overcame my nervousness so completely that I have had no trouble since then."

"The course cleared up several difficulties which were in my mind. They were things that I never clearly understood until I entered Mental Hygiene."

"In dealing with the ..... Company when I had my store. I could have told them a lot of things, but overlooked their mistakes somewhat and solved a lot of the different issues."

Five answered the question in the negative, six made no comment, and two others expressed themselves in so confidential a manner that it seems better not to use their remarks.

Many students voluntarily added opinions on the reverse of the questionnaire, and some of these are more significant than the answers to specific questions.

One young man wrote as follows:

"I believe this questionnaire was sent out too late. In two years, many things are forgotten. Although I believe every one in the class picked up some little thing to improve his or her character or personality, many of us do not remember whether we got it from the course or not.

"Although I didn't pass the course with flying colors, I am sure I got enough out of the course to be glad that I took it. In fact I don't see how any one could be 'flunked' who took the course. Although each little technicality is not learned so that it can be put on paper for a passing mark, the fundamental or basic point is known by the student who is in the class and pays attention to the recitation of others around him."

One girl said:

"Mental Hygiene class was the 'Dawning' for me. I realized my personality problem before I entered the class, but it was not until I was in the class that I began to do anything about it. I am not continually in conflict with myself as I used to be. To-day, I believe, my personality is much more nearly like the one I have been striving for. Most important of all, I have learned to like people.

"I expect that Mental Hygiene class will help me for many years to come. I plan to become a nurse, and if ever I need a knowledge of people, and how to get along with them, it is here.

"There were two subjects I wish we might have devoted more time to—sex and leadership. I particularly liked the assignments made asking us to analyze ourselves."

Another girl said:

"Two years ago, before I took the course, I was terribly jealous of my sister, and tried in every way to be mean to her. I used to sneak petty little things from her, which would only cause a quarrel. Since, I have learned how foolish it was and have stopped."

One boy, now a sophomore in college, said:

"In many instances during my freshman year at college I found myself at a distinct advantage for having the information which I

acquired in my Mental Hygiene class. It has proved very useful to me, and it would be my suggestion that all students study at least certain phases of the subject matter."

Other comments were:

"I suggest that you give the class a lesson on courtesy about opening the doors for teachers and other students. Also give them a lesson on introductions, as there are many who never learn this unless from other students or in Mental Hygiene. I enjoyed the course very much and think this class is one of the most important in all of my subjects, and I think it is proving to be a very successful experiment."

"I am all for the course. Although it has been only two years I have found it to be a great help to me. Although I haven't placed my finger on particular things, I feel that after taking a course of that sort a person feels more sure of himself. It gives him a broader outlook on life. To know that you are like other people and that they have very much the same troubles that you have has given me the feeling of freedom. And, frankly, I think—in fact, I'm sure—that I first found that out in your class."

"It is a fine thing for the students to be criticized by the class. However, some students will just put down vicious criticisms, which in reality do not exist.

"I think some sex education is also good in the class, as I know many young people do not get the knowledge out of their homes that they should.

"More emphasis should be laid in actually helping each student than in giving too many tests in order to mark report cards. It is too bad that grades have to be given in a course of that nature.

"On the whole the course was very helpful and interesting, and as it was the first time it was given, I think it worked out very well indeed."

"I think Mental Hygiene is very important. We study bodily actions and if we get sick we go to a doctor or get medicine to ease the pain; but if we get irritable, crabby, hard to get along with, etc., we just wait until it blows over. I believe if you learn to check these things, and I know I've done it myself, life is much happier for you and those whom you live with."

"I think Mental Hygiene is a wonderful course and should be in every school. It has helped me in my married life and I think will continue to for the rest of my life."

If the information presented above can be regarded as a measure of the teachability of mental hygiene in high school, then we can continue our efforts in this field with more confidence that adjustment education is not just another fad, but has its excuse for being in a real need, as expressed by the approval of citizens after they have left school.

MENTAL HYGIENE OF THE SENIUM

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THE period of life known as the "senium," or "old age," is associated with problems many of which are peculiar, distinct, and often quite remote in character from those encountered in infancy and the earlier adult years. Much of the knowledge gained from the study of the physical and mental behavior of young and middle-aged adults can no more be applied to the period of senility than to the immediate life of the child. Moreover, "age" is an extremely elastic term which, in physiological concepts, can rarely be used in its chronological sense, as what is understood by "age" in terms of structure-function may overtake a man in his earlier years or may manifest itself in irregular retardations and dysfunctions of special sets of organs, according to the results of predisposition, previous diseases, and the stress and wear and tear to which the body has been subjected in its journey through life.

Each individual is born with certain endowments or capacities and with the ability to mature. These capacities are unequal in strength and function, there being many degrees of power, and it should be recognized that a number of them grow progressively weaker after the individual has passed the prime of life. These irregularities in capacity account for many, if not most, of the individual differences in attitude and behavior. In old age, whether chronological or physiological, some important endowments and functions have attenuated, have become distorted through conversion, or have disappeared entirely. Thus we are dealing with a different individual after age has required the readjustment of the whole psychobiological reaction setting.

As compared with the interest taken in children's problems by general physicians, psychiatrists, psychologists, social workers, and public-welfare organizations, the interest and care accorded the aged is insignificant, amounting to nothing less than neglect. Here and there one finds a small organiza-

tion interested in old people, but chiefly from the standpoint of housing and feeding—in other words, with an eye to economic welfare. Where do we find journals devoted to the welfare of the aged? One may admit some excuse for this attitude on the basis that the aged are generally, although by no means always, economically worthless, and become more so with added years, while the child has an increasing economic value and, in addition, a prospective maturity which may be favorably influenced by helpful interference at the proper maturation phases.

In as much as one person's tissues may become senile long before another's and reveal what is known as senility in degrees varying from that manifested by other individuals, we must expect to find and we do find varying degrees of functional loss and distortion. Categorically we refer to the span of life after the sixtieth year as the senile period, and our remarks in general refer to this period, although they apply as well to exceptional cases in the younger age periods. (Some elements in the senile deterioration begin at birth or even before, and usually at forty-eight or fifty years the changes characteristic of senility become evident in the human organism.)

Senility is simply one aspect of the developmental process. The gradual change from the adult state to old age is essentially a normal biologic reaction characterized by certain physiologic alterations which in themselves complicate and disturb the life adjustments. Moreover, like all other processes in the living organism, these changes are often accentuated or distorted by pathologic variations. In every instance, there is some degree of senile atrophy of cells, tissues, organs, and organ systems, and in a complex organism like man, different cells and tissues grow old at different rates of speed. That both men and animals gradually age—that is, become senile in the course of progressive development—is indicated by the decrease in the metabolic rate.

Although our knowledge is yet far from complete as to vascular and endocrine changes that contribute to or that are associated with senility, it is certain that there is normally a decrease in the elasticity and contractibility of the blood vessels, which may be so excessive as to constitute pathologic arteriosclerosis, and which in any case throws an increased

load upon the heart and interferes as well with the general nutrition of the body.

One might discuss the nature of the process of senescence in the light of a number of hypotheses, including those proposed by Metchnikoff, Weismann, Goette, Carrel, Steinach, and Voronoff with reference to endocrine, metabolic, cellular, autocatalytic, and humoral factors, each of which contains supportive evidence. However, opinions on the subject may be divided in a general way into two main groups: one considers senescence as a phenomenon appearing as a life characteristic of the multicellular body as a totality, while the other regards it as an inherent property of the individual cells. The irregularities noted in the senile developments in the various organs and parts of the body would favor the latter point of view. Moreover, animal cells exhibit properties similar to the changes noted in the aging of colloids, such as loss of absorptive power, changes in stability, and tendency to dehydration.

With time, body cells, like chemical catalysts, decrease their activity and finally lose it altogether. Any increase over the usual activity of animal cells shortens their lives, while a decrease in activity lengthens them. It may be said, therefore, that the longevity of the cell varies inversely as the rate of energy expended in metabolism,[1] and the fundamentals of longevity are sought among the factors of heredity, sex, race, and mode of life. It has been pointed out that the basal metabolism of people above the age of fifty years is lower than that of younger people, and that the decrease is brought about gradually without a sudden drop in any particular age group; the rate of decrease is about 3 to 5 per cent in each ten-year period.[2]

Along with the diminution in physical strength and activity there appears a depressive mental attitude, probably due to the recognition or the anticipation of the approach of old age, with its unfulfilled hopes and plans, and the

[1] See "Senescence an Inherent Property of Animal Cells," by N. R. Dhar (*Quarterly Review of Biology*, Vol. 7, pp. 68–76, March, 1932). See also "*Kolloidchemische Betrachtungsweise seniler und präseniler Gewebsveränderungen*," by *A. von Braunmühl* (*Zeitschrift für die Gesamte Neurologie und Psychiatrie*, Vol. 142, pp. 1–54, 1932).

[2] See "Basal Metabolism of Old People," by Yoshiaki Kise and Takumi Ochi. *Journal of Laboratory and Clinical Medicine*, Vol. 19, pp. 1073–79, July, 1934.

increasing difficulty in dealing with the ordinary problems of life—a failure of compensation at the psychological level where conflicts, formerly resolved successfully, now break through and overwhelm such constructive forces as are available. The failure of the psychological protective processes may be enhanced by, or associated with, the vascular changes of senility, as well as with other complicating physical and toxic factors.

Among the universally recognized features of senility, the effects of which should be combated by all the means at our disposal as physicians, are the impairment of retentive ability and the general failure of memory, depression, fears, and self-depreciation, with loss of confidence in ability, all of which may be increased or brought into prominence by overwork or fatigue in complicated situations which were once handled with ease, but which now, due to increased fatigability, become almost impossible burdens. Many are able to work steadily and comfortably without difficulty, but at a much lower mental level than the original one attained with ease; and as the old person is struggling to keep his place in the world, the hygienist should weigh all factors carefully before interfering with any work program. The "puttering" activities of the aged, so frequently called "imaginary duties" by their relatives and associates, who are annoyed by what appears to be unimportant work or actual obstructions to the work of others, are of the utmost psychobiological importance to the individual, as they are saving mechanisms by which he holds on to his ego importance in the world.

There are as many differences of character and reactions among the aged as among developing children. We find degrees of irritability especially at night, fear responses, reactive depressions, addiction to routine, dissatisfaction with the work and lives of others, and mild, but often justified, ideas of persecution. This latter develops on the basis of lack of sympathy and understanding on the part of others of the emotional investments of the aged.

Many old people become sad, disillusioned, and disappointed, and life often becomes empty and miserable as they grow more or less incapable of playing useful rôles in the family circle. However, they are not infrequently prevented from making themselves useful by impatient relatives who

neglect to make the necessary special arrangements to aid the adjustment or who fail to give any special attention to the problem. They are too often regarded as a heavy burden upon the finances and emotions of the family group, with the result that they become the objects either of open antagonism or of suppressed and subtle ill will. Old-age pensions are relieving many such family situations.

Many persons find little if any difficulty in making the adjustments incident and necessary to old age. Others are reluctant to relinquish the activities formerly pursued, wish to continue their work and their pleasures as formerly, and in spite of an obviously failing capacity, become charged with the belief that they are as good as ever. When pressure is brought to bear upon one of these situations, a great deal of tact is necessary in as much as a pathological response may be easily effected. The realization of what is interpreted by them as a great loss may precipitate an episode of some severity, and still further complicate the powers of adjustment.

"The subject of old age has never been a popular one with the medical profession."[1] There are more reasons for this than the one usually offered—the lack of economic importance of the old person in our society. Although there are plenty of exceptions, old people are not as a rule pleasant patients, and moreover the conditions and types of disease from which they suffer are apt to be therapeutically hopeless or at best to lend themselves only to symptomatic relief. It may also be said that the aged are unpleasant, even repulsive, from the æsthetic standpoint, the degree being determined both by the condition of the patient and the æsthetic state and capacities of the observer. They are frequently sufficiently repelling to counteract the sympathetic feelings and tendencies of those inclined by nature to respond to helplessness, personal difficulties, and illness in others. "We can readily account for the public neglect of the aged. Human sympathy is universal in its scope, but not in its application. Instinctively or subconsciously, economic values, social relations, the æsthetic sense, and other factors influence the directions in which sympathy is applied. . . . Optimistic philosophers of all ages from Cicero to Jean Finot describe old age as being beautiful,

[1] "The Neurology of Old Age," by M. Critchley. *Lancet*, Vol. 220, May 23, 1931. p. 1119.

but no philosopher has ever declared that the aged themselves were beautiful."[1]

There are several physical and mental characteristics of old persons which, with exceptions, account for their unpleasantness or repulsiveness to others. Of the former, there are the various evidences of physical decay and distortion, which carry with them implications threatening the future: disagreeable odors and frequently neglect of clothing and other duties of cleanliness and personal hygiene. The mental reasons are probably by far the more important, and the behavior of the senile is frequently annoying, displaying peevishness, irritability, wilfulness, childishness, ill-tempered and offensive behavior, expressions of depressive affect, foolish obsessions and suspicions, and tendency to prolixity and to prolonged conversations in which past experiences are related without discrimination as to what is important and what irrelevant. The aged are usually selfish, or at least their attitudes and reactions in special situations are so interpreted. Many suffer from ill health over which they become worried and depressed, some to the extent that suicide is selected as a way out. Some combination of these expressions is present in practically every aged individual, and if it is not neutralized by an understanding attitude on the part of companions, it will act destructively and counteract sympathy and active interest in the welfare of the old.

There are logical reasons for the unpleasant mental attitude of the aged person. The energy, capacity, and enthusiasm of youth are gone, and with them a certain degree of the ability to adjust to the complex and ever-changing circumstances of life. As a result, in the midst of this decline in life, their attitude can be none too optimistic, and it is not strange that any unusual occurrence in the family routine, any increased pressure of extraneous circumstances, stressful situations, or unexpected disappointments, may partially or even totally overwhelm them.

The retained constitutional capacity for adaptation may in large part determine whether the reaction released will be merely an exaggeration of the usual senile tendency to ruminate over losses, a domination by self-centered ideas or regretful thoughts and doubts of the present, or feelings of

[1] *Geriatrics*, by M. W. Thewlis. St. Louis: C. V. Mosby Company, 1919.

inadequacy, weariness, and resignation toward the future. When the make-up is more rigid, rendering adaptability still more difficult, there will be more serious responses, with depression in pure form, or with agitation and self-depreciation, accompanied by pronounced sleep and digestive disorders. Fluctuating mental confusion, apathetic states, and episodes of elation resembling a manic reaction, with exaggerated ideas of self-importance, are occasionally released in similar circumstances.

In some seniles there is a phase of behavior which is known as "sexual recrudescence." This may express itself in the form of foolish infatuations for younger persons of the opposite sex, revealing itself in talk and silly actions noticeable only to the immediate family or to the interested neighbors, or its expression may become a source of active annoyance to the household servants, to others outside the home, or to acquaintances living at distances who may be selected as love objects. The activity may be diffuse or sharply localized to one love object. It may lead to medico-legal action, and in the case of old men with latent or revived character twists or with psychoses, it may result in the seduction or rape of young children or of mature women. This same trend or drive may lead to marriages displeasing to relatives because of inheritance or other rights. These marriages or threatened marriages may become the foci of many unhappy affairs, while the immediate participants may be discontented or happy in their intimate personal relationship.

In women, in addition to the possibility of an erotic flair in senility, the maternal instinct—or whatever it is that is usually known as the "maternal instinct"—may be markedly in evidence. This is true even of aged virgins, and the tendency may survive even after the higher intellectual faculties have disappeared, as is amply demonstrated daily on the wards of large institutions for the mentally ill, where aged women habitually play with dolls or become attached to feebleminded and often partially helpless children for whom they show genuine maternal solicitude, including feeding, personal hygiene, caressing, and attention to general welfare and protection. Such a self-appointed "mother" often becomes seriously disturbed and unhappy if the child dies or is otherwise removed. The persistence of this motherly atti-

tude is to be noted not only in institutional seniles, but also in the normal ones at home, where their need for love and their craving for attention create family difficulties, particularly in the grandchildren situation. The possible grandparent-child-parent relationships, hates, loves, jealousies, conflicts, and complications are too well known to elaborate here.

Why some seniles show merely a quantitative decrease in abilities, capacities, and adaptations, while others exhibit pathological deviations and finally develop active mental disorder, is an unsolved problem which emphasizes the need of studying the physiologic and psychologic aspects of old age with more precision. So far, investigations of the physical factors have not only failed to reveal important differences, but similarities have been found in the histopathologic picture in the brains of cases of senile dementia and normal seniles. In the main, the histopathologic changes consist of shrinkage, liquefaction, and lipoid increase in the neuron cells of the cortical layers, the corpus striatum, and other large nuclei; an increase in neuroglia; and frequently the formation of the so-called "senile plaques." As a matter of fact, the diagnosis of senile dementia as such cannot be made histologically, as the line of demarcation is too thin between it and the normal changes characteristic of simple senility. Moreover, there is a lack of correlation between the severity of the pathological changes and the degree of intellectual impairment, and equally severe alterations have been found in the brains of old persons of normal mentality.[1]

Gellerstedt[2] found histopathologic changes described for senile dementia in brains of aged persons without dementia, which findings are in keeping with the work of Grunthal[3] and of Rothschild. A report by Scheele[4] on senile dementia observed in twins emphasizes a similarity in clinical course

[1] See "Pathological Changes in the Senile Psychoses and Their Psychobiologic Significance," by D. Rothschild. *American Journal of Psychiatry*, Vol. 93, pp. 757–88, January, 1937.

[2] *Zur Kenntnis der Hirnveränderungen bei der normalen Altersinvolution,"* by N. Gellerstedt. *Upsala läkareförenings förhandlingar*, Vol. 38, pp. 193–408, 1933.

[3] *"Klinish-anatomisch vergleichende Untersuchungen über den Greisenblödsinn,"* by E. Grünthal. *Zeitschrift für die gesamte Neurologie und Psychiatrie*, Vol. III, pp. 763–818, 1927.

[4] "Heredity Bearings on Senile Dementia," by R. T. Scheele. *Zeitschrift für die gesamte Neurologie und Psychiatrie*, Vol. 106, pp. 546–62, 1926.

and symptoms, and also the fact that the two psychoses were in many respects similar to the mental disorder from which the father of the twins had suffered. Although Pearl and Greef [1] infer from their studies on longevity that hereditary factors play a rôle, what relationship, if any, exists between longevity and pathologic senile changes is a subject for future research.

Everywhere the usual personal problems will arise and must be met by the individual. If there is an incapacity to adjust to the more serious personal problems, these situations may precipitate a senile psychosis. If there is sufficient unimpaired compensatory ability in the integration, the adjustment may occur without the development of a psychosis. There is a wide range of difference between individuals in their capacities to compensate for untoward environmental factors as well as for the numerous lesions in the body, including the brain. A lesion in the brain, a toxic focus in the body, or a thwarting family situation may release a psychosis in one individual, while another individual may bring into play compensatory capacities and adjustments and show no evidence of a psychosis.

There are a number of aspects to the situation in the actual practice of mental hygiene as applied to the senile. Hard-and-fast rules for avoiding or relieving troubles cannot be formulated; each case is a problem for special study and recommendations. However, certain general considerations may be kept in mind by those who have responsibility for the aged. As examples of opportunities for helpful attitudes on the part of physicians and others, one might point out the following:

1. Utilization of the senile individual economically, or at least in a fashion to assure him (or her) that he is still a part of the world of affairs, is important and necessary to the business of whatever forms the background of the situation. Moreover, many facts indicate that a reasonable variety in mental occupation is a factor in retarding mental senility. What we often call mental fatigue may be something far less transitory than fatigue in the ordinary physical sense, and seniles fatigue easily and restitution is slow. Therefore,

[1] "Biology and Human Trends," by R. Pearl and S. Greef. *Journal of the Washington Academy of Science*, Vol. 25, pp. 253–72, 1935.

changes of work and frequent rest periods should be arranged.

2. The senile individual should be relieved as far as possible from worry, mental strain, anxieties, and feelings of financial insecurity, and should be periodically withdrawn from the whirl of effortful existence. Some enjoy spending longer periods of time under simple, pleasant conditions in retirement, away from annoyances, out of the influence of the perpetual sense of hurry and the sequence of incidents which exhaust the attention and which are nowadays a part of practically every environment.

3. With the gradually devitalizing processes in mind, especial care should be taken to avoid physical discomforts, vitiated air, infections, and overeating. Many elderly people eat too much and are unwise in their selection of foods. The relief from sluggishness, obstipation, and irritability that can be obtained by making certain sensible modification in their diets and giving attention to their elimination processes is often astounding.

4. The senile should be protected from injuries, as they readily develop the post-traumatic constitution, with its characteristic changes in disposition. A physical trauma may definitely change the personality either temporarily or permanently, or it may merely increase the general irritability which often becomes prominent in old people, particularly at night and early in the morning. Physical injuries may produce or increase a tendency to hypochondriasis and self-scrutiny, as well as increasing the feeling of uncertainty that is already present.

5. It is important to avoid any heavy burden on the sense organs through which exhaustion of the central nervous system may occur. The exaggerations of natural weakness or partial loss of the functions of sight and hearing often seriously impair social efficiency in the contacts made by senile individuals and help to explain some of the personality changes. Tolerance of the situation and some aid from others may do much toward preventing a narrowing of the sphere of interests and a tendency to focus attention on the self.

6. The younger and more able associates of the senile should recognize and make allowances for the, at times, obvious loss of acuity, in dealing with situations that require fine discrimination and tact, in individuals who in their earlier

days were able to handle such situations perfectly. A little diplomacy and encouragement may do much to relieve their tension. In many disagreeable seniles, the picture is merely an exaggeration of an originally somewhat difficult personality of the projective type, in which self-control is now lost or weakened, allowing the character traits free play.

7. Tolerance and understanding should be exercised in connection with those aged people who by virtue of a temperament that may become exaggerated or distorted by complicating factors show a marked egoism, along with uneasiness, restlessness, and a tendency to harp on their difficulties. Some show a pronounced vulnerability of the psyche to small or relatively insignificant misunderstandings, which they may interpret as insults that provoke aggressive responses; while others react with a feeling of panic and complete helplessness whenever complicated situations present themselves. Thus the practical handling of these problems may be complicated in various ways, and require some special study.

One cannot emphasize too strongly that chronological age is not an index of physiological age, and that physiological age is no index of psychological age or deterioration. Therefore, each individual senile reaction must be considered in relation to the particular situation to be evaluated. But most cases should be approached with a realization that the physiological and mental mechanisms are less elastic than formerly, so that adjustments and compensations may not be readily accomplished. The application of sound common sense, mixed with an understanding of the problems faced by the aged and reinforced by human sympathy, does much to smooth out the difficulties inherent in the nature of human relationships.

THE USE OF PUPPETS IN UNDERSTANDING CHILDREN *

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THE Children's Observation Ward of the Psychiatric Division of Bellevue Hospital, under the guidance of Dr. Lauretta Bender, senior psychiatrist in charge, cares for approximately 600 children during the year. These children, whose ages range from two to thirteen years, are referred to the ward from the children's courts, mental-hygiene clinics, social-service agencies, the board of education, and private physicians. The daily census is 48 children.

The children generally stay on the ward for a period of one month. For various reasons, such as the need for different activities, for protection from cross infection and injury from older children, and for special types of observation, the children between the ages from two to six—in other words, the pre-school children—are cared for in a separate set-up known as the nursery.

All our children suffer from a variety of diverse behavior disorders. Their paramount need is a psychotherapeutic need—an opportunity to work out their problems, a chance to give some free expression to their aggressive tendencies and to verbalize about and clarify the emotional, social, and intellectual difficulties that they have encountered in the family set-up, at school, or in the social environment known as the neighborhood. Feelings of guilt, fear, apprehension, or anxiety that have resulted from these problems must be overcome.

To carry out this aim, various activities have been introduced on the ward. The board of education maintains two classes for the children of school age. Through the facilities of the Federal Works Progress Administration, art classes, recreation facilities, music projects, and opportunities for

* Presented before the Eighth Biennial Conference of the National Association for Nursery Education, Hotel Pennsylvania, New York City, October 27, 1939.

clay modeling have been made possible. Among these activities are puppet shows, given once a week by adult puppeteers and performed by the children themselves, whenever they are inclined to do so.

The most frequent problem that confronts us in our nursery children is that of determining whether their behavior disorders are due to mental retardation on a congenital or organic basis, or whether emotional problems or other personality difficulties are the responsible factors. The children in our nursery group have the usual opportunities offered in nurseries to handle plastic and graphic material, to listen to music, dance to simple rhythms, and engage in individual or group play. In this respect our nursery does not differ from any other nursery set-up. What makes our group different are the following factors: All of our nursery children show deviations of behavior. The activities used serve not merely as recreational media, but as a means of understanding and grading the behavior of these children. While subjecting these children to normal situations, we have an opportunity to retrain them for a normal environment. The most important aspect of our nursery life lies in the fact that we use specific psychotherapeutic measures which enable us to understand the fantasy life of these children. We gain insight into their problems, and pass this insight on to the children by giving them ample opportunities actually to resolve their problems.

An account of how we have learned to understand the child through puppetry necessitates a few words about the type of puppets and shows that we use. All of our puppets are hand puppets. This "Punch and Judy" type fits the hand like a glove. Every movement of the puppeteer's hand or arm is immediately transmitted to and followed by the puppet, in contrast to the marionette or string puppet, which is separated from the player, his movements being transmitted to it indirectly through strings or wires. This close connection between the puppeteer and his puppet allows for quick, direct, obvious, and forceful actions. This is important because it allows for the presentation of various attitudes and situations which even the nursery child can grasp and understand.

The chief character of all our shows is Casper. He is the product of European folklore, and for centuries has been

known as Punch in England, as Guignol in France, as Casper in Germany and Austria, as Casparek in Czechoslovakia, and as Petrushka in Russia. This figure basically represents the wishes and desires of the man in the street. He displays common sense, and shows great interest in biological functions such as food intake, digestion, and elimination. His aggressive behavior is a curious mixture of bravery and cowardice.

Since we play for children, we had to change this adult figure into a boy. We kept most of his main characteristics, although somewhat reduced to a childish level. It is obvious that Casper and his fellow puppets cannot be simply defined in psychoanalytical terms, but there is no question that the various sides of the total psychic structure are reflected differently in the various puppets. Casper is the expression of strong infantile desires which demand satisfaction. He knows that he must adapt his drives to the demands of reality. This satisfies the demands of the super-ego. We must, therefore, see in Casper something of the Freudian "idealized ego" which reaches for reality without being in conflict with the "id" or pleasure principle.

The monkey, which plays an important part in some of our shows, gets his gratifications easily and corresponds in many ways to the "id" which has not been restricted. Oral aggression is personified in the alligator. Casper's parents take over the rôle of the super-ego. We believe that the child sees his parents as dual personalities. The Good Father and the Good Mother love and protect the child, feed him, and show him affection. The Bad Father and the Bad Mother inhibit the pleasurable impulses of the child and train him in a manner not always agreeable to him. The Bad Mother in the puppet show is the witch. She is aggressive toward Casper, denies him food and rest, and forces him to do hard work. The part of the Bad Father is portrayed by the giant, the magician, and also partly by the cannibals. The giant, through his enormous body, is a physical threat to Casper. The magician, through his magic and clever scheming, is intellectually superior to Casper.

I may mention here that we came to these conclusions as to what the different characters mean to our children, not on the basis of our analysis of the plays, but through the reactions of the children. We were surprised ourselves when we

learned, for instance, that the cannibals represented the parents. It may suffice, then, to say that the puppets represent specific persons directly or indirectly, or stress specific sides of personalities.

It is impossible to discuss here all of our shows; therefore only two of our plays will be described in brief, synoptic form. *Casper in Africa* is very much liked by our small children because this play contains very little verbal material and stresses easily understood actions. It is full of repetitions and allows for a great deal of experimentation with situations on Casper's part.

When the curtain opens, Casper appears somewhere in Africa. He is hungry and looks for food. He finds a banana, but before he has a chance to eat it, a monkey takes it away. Casper gets himself more bananas, which also are promptly stolen by the monkey. Casper is bewildered by the disappearance of his food until he finds out that the monkey is the culprit. Casper and the monkey fight with each other. Then, realizing that together they can get all the food they want, they become friends.

Casper is alone on the stage and finds a trinket. While he goes off to get some wrapping paper, an alligator appears and takes the trinket away. Casper blames the theft on the monkey and beats him. The sudden reappearance of the alligator makes Casper realize that there are other forces in this strange environment that he has to cope with. The alligator attacks Casper, but the monkey helps him finally to kill the common enemy.

Before the alligator is finally overpowered, however, many amusing repetitions take place. The alligator may run away in the middle of the fight, leaving Casper and the monkey hitting one another. Or the alligator may seem dead, but while Casper is talking to the monkey, may come back to life suddenly and attack both figures, and the fight starts all over again. All these repetitions lead to new experimentations with the same situation, and mastery of it is achieved through trial and error.

The beginning of the third act shows two cannibals who speak a gibberish sort of language and perform a wild dance. They capture Casper. Again the monkey appears in time to save him. The same repetitions as those in the fight with

the alligator are brought into play. The cannibals, however, are not killed, but are taken back to America with Casper, who feels that they need training and an education.

In the light of the fact that the puppets represent specific persons directly or indirectly, or stress specific sides of a personality, we may then say that in this show Casper represents a very small child in a strange world. His first sensation is hunger. In his attempt to satisfy his hunger, he comes into conflict with the monkey which, as we have said, represents somewhat the unrestrained pleasure principle. Oral aggression is encountered and mastered. The cannibals, with their queer body movements and strange language, are perhaps the first impressions a small child has of his own parents. Repetitive action on Casper's part, composed of aggression and investigation, is necessary before he learns the true nature of these new forces. In other words, this show represents some of the basic experiments the small child goes through in his developmental growth. The nursery child can easily understand what goes on on the stage because complicated logical word structures are absent. Simple, direct, and obvious action dominates the show.

Rock-a-bye, Baby was written especially for a nursery child whose unrestrained sibling rivalry had resulted in a serious behavior disorder. The opening of the show finds Casper trying to play with his mother. She finds all sorts of excuses for not playing with him. She urges Casper to get ready for dinner. Casper has been used to being washed and led to the toilet before dinner by his mother. When she now refuses to take care of his hygienic needs, Casper rebels. Finally the mother tells him that from now on he must learn to be independent because she expects a baby. Casper does not like this sudden news. He does not want anybody to come between his mother and himself. His father comes home from work. He sends his tired wife off to bed and cautions Casper to be quiet, so that his mother may be able to rest. This curb on his liberty enrages Casper. He blames all these changes on the unborn baby, and the foundation for his sibling rivalry is laid.

At the beginning of the second act the mother appears with Casper's little baby sister and puts her to sleep. When Casper enters the house noisily, his mother stops him and

makes him take a nap, too. The baby begins to cry. The mother rushes in and takes out the baby to change its diaper. This gives Casper a brilliant idea. When the baby cries, the mother comes right away to take care of the baby's needs. Will she take care of him when he cries? He is greatly disappointed when his mother does not respond to his crying. The baby is brought back to the stage, freshly diapered. Casper releases his anger against his little sister by hitting her. The baby's cries quickly bring back the mother, and Casper realizes that his aggressive acts against the unwanted sibling result only in centering more attention on her.

In order to regain his mother's undivided love and attention, he looks for an opportunity to get rid of the baby. This chance presents itself when the mother goes out shopping, leaving Casper at home alone with the baby. Casper calls the witch and begs her to take the baby away. The witch does not kidnap the child, but compromises with Casper. She makes the baby sick by putting a spell on its milk bottle. The returning mother finds her little infant desperately sick. With tears in her eyes, and full of remorse for having left the baby out of her sight, she rushes the baby to the hospital.

Casper suddenly becomes aware of the fact that by harming his baby sister he has really harmed his mother, who, after all, is the great love object he wants to keep for himself. By harming his mother, he has also harmed himself by putting himself in danger of losing his mother's love. In order to prevent this, he recalls the witch and begs her to make his baby sister better again. When the witch refuses to comply with his wishes, he beats her into submission with a stick. No sooner has he forced the witch to take off the spell than he kills her, thereby symbolically killing his own bad wishes against the baby.

The mother returns from the hospital with a now healthy baby. The whole family, including the father, are happily reunited. On her way home from the hospital, the mother has bought some ice cream for Casper. Interestingly enough, the ice-cream part was missing in our original version of the play. It was included later when most of our children insisted on some visible sign of the mother's love for Casper.

All the children cared for on the ward see the weekly puppet show. Before the show starts, the children are encouraged

to react freely to the changing situations on the stage. They are urged to shout warnings, to give advice, to help Casper in the solution of his problems, to persuade hostile characters to spare Casper, to voice their approval or disapproval, and so on. This disapproval may be directed against Casper as well as against any one of the other puppets. The nursery children, like the rest, readily avail themselves of these opportunities for uninhibited expressions.

Notes from our case material will demonstrate how some of our children react to the puppet shows, and the deductions these reactions allow us to make.

Dennis is a six-year-old Negro boy. He was sent to us with a history of epileptic seizures and temper tantrums. We observed no seizures, but found him to be a hyperactive, aggressive child. He was asked to tell what he had seen on the puppet stage during *Casper in Africa.* This was his story:

> "The big, bad wolf came and he took the banana. They belong to that little man. Then he said: 'Don't take my banana,' and then the big, bad wolf came again, and he was fighting, bing, bang, boom! And he hit him right on the mouth."

Dennis was asked: "Weren't you afraid when the big mouth [the alligator] came on the stage?" To which he replied: "No, I wasn't scared, because Casper had a brother with him."

The most important idea that Dennis got out of the show is the fact that Casper is aggressive, and that he fights. It does not matter whether Dennis correctly identifies the alligator by name or not. After all, what both this reptile and the wolf have in common is a big mouth with sharp teeth. The monkey becomes Casper's brother. This gives Dennis a certain sense of security. He sees no reason to fear for Casper, because Casper is not alone.

During the following week, this boy saw *Rock-a-bye, Baby.* When the mother urged Casper to go and wash himself, Dennis got up from his seat and shouted to Casper's mother: "You go and wash yourself! You are dirty, you have a dirty face!" During the second act, Dennis shouted to Casper: "Get yourself a stick and hit your mother and the baby!" The next day Dennis told the following story:

> "Oh, yes! There was the mother with the dirty face, and I told her 'Wash yourself,' and you [the puppeteer] gave the baby bad milk, and

> the baby died. You should be ashamed of yourself doing that to a baby. You should have taken a stick and hit the mother and the baby, but not kill the baby."

When I asked Dennis: "Why should I hit the baby?" he answered: "Because the baby did something in his pants." Again we notice the emphasis that this boy puts on aggression. Epileptic children are always more interested than are normal children in aggression in all its forms, including verbal aggression.

This boy's behavior at home is carried over into the puppet show when he gets up and talks back to Casper's mother. Dennis, however, is not the only nursery child who reprimands the puppeteer for letting Casper make an attempt on the baby's life. Almost every time we play this show, some of the small children tell the puppeteer after the show: "You ought to be ashamed of yourself!" "Shame on you, you are bad!" "I am going to tell your mother on you." Not infrequently the puppeteer is actually hit by some of these nursery children. They see in him the puppet Casper and feel the need to defend and to protect the helpless little infant from him. This proves for one thing that this show contains a great deal of material even for those of our children whose specific problems are not those of sibling rivalry.

Walter, a five-year-old white boy, was sent to us from an orphanage with the complaint that he was aggressive, disobedient, and resistive to training. On the ward he was flighty, restless, cried easily, and fought a great deal with the other children. This is a common behavior disorder in unloved, institutional children. His response to the puppet show was as follows:

> "Once upon a time the puppet show had a stick, and it smacked the monkey. All the people were there, and the puppet show said: 'We have a birthday.' That was all."

This answer shows that Walter got more out of the play than the aggressive acts. Whenever some of our children have birthdays while on the ward, it has been customary for us to let Casper distribute candy to all the children in the audience. For this child, who had been brought up in institutions and deprived of a full social life, the puppet show is also a social affair in which everybody participates and candy is passed around. This boy probably did not know the proper

meaning of a birthday. As we have already mentioned, food, especially sweets such as candy and ice cream, are regarded by our children as visible signs of maternal love. Receiving sweets during a puppet show, then, perhaps means for this child that he is liked, loved, and accepted. The puppet show in itself may not be of specific therapeutic value to such a child, but indirectly, in its social settings, it may give him reassurance and security.

Joan, a five-year-old white girl, was brought to us with complaints of bed-wetting, soiling, and general infantile behavior. Joan is the third of six children, all of them unwanted by their mother. The mother found it difficult to care for this child, because Joan was very aggressive against her younger siblings. We were told that she often would take away the milk bottle from her younger siblings and drink the milk herself. On the ward she was restless and fought with the other nursery children. When she was questioned about *Rock-a-bye, Baby,* she at first denied having seen the show. When she was asked: "Where were you during the puppet show?" Joan related the following tale:

> "That was a cute baby the mother got. The baby was cute. The mother took the baby home, and the baby's bottle went home, too. The baby cried and it wets its pants, and the mother came and changed the diaper and took the baby home. The mother never brought out the bed, and the baby had to sleep on the puppet show [stage]."

Joan was asked: "Do you wet yourself sometimes?" "Sure I do," she said, and continued:

> "Then the baby wet the bed, and then the baby wet her diaper. Then the baby sticks out her tongue to the mother, and the mother gives her a good licking. The baby laughs and says: 'Dopey mama, ha, ha, ha, dopey mama!' Then the baby says [Joan began to shout]: 'Dopey mother! Dopey mother!' Then the papa said: 'Don't you say that, bad baby!' The father said: 'Don't say that again! I give you a licking! I put you to bed! Don't say that again! If you do, I'll give you a licking!' Then the baby said: 'Dopey father!' The father says: 'I give you a licking! What do you do that for to your mother?' "

Joan was asked: "Does the baby like her papa and her mamma?" She became very aggressive, almost assaultive and shouted: "That's what you say. Will you please shut up!" In a loud and angry voice she continued her story:

> "Now, the mother is in bed. Now she sits on the pot and makes wee-wee. Now she takes the pot to the toilet and puts the wee-wee in

the toilet. Then she bites the baby in the behind and eats the baby up, and then she has no more baby. Then the mother goes away, and the father goes away."

It is impossible to analyze fully all of Joan's problems. Only the more obvious ones are taken up here. Joan complains that Casper's mother never brought the bed, and that therefore the baby had to sleep on the bare puppet stage. It is true that in the show the mother lets her baby sleep on the stage without a bed. Our children do not object to this, because many imaginary things and acts take place during these shows. Joan, on the other hand, strongly associates "baby" and "sleep" with "bed." To her a mother who allows her child to sleep on the bare floor, without the comfort of even a pillow, is obviously a mother who does not care how and where her child sleeps. I mentioned above that Joan and her five siblings were conceived and born against the mother's wishes. Whatever care and attention this mother gives her children is given sparingly and without much consideration. Joan keenly detects this lack of interest in Casper's mother, a lack that is so familiar to her from the treatment she has received from her own mother.

Having found this similarity between her own mother and that of Casper, Joan puts herself in the rôle of Casper's baby sister and gives an exhibition of her behavior toward her own mother. This girl soils and wets; therefore a great part of her story deals with elimination. The baby laughs when it is punished by her parents, and continues with her verbal attacks on both of them. The father seems to be a weak character because he threatens without carrying out his threats. The mother is aggressive. She punishes the baby on that part of the baby's body which is responsible for much of the unnecessary work it gives the mother—namely, cleaning up the soiled and wet clothes and bed linens. The mother's biting and eating up of the baby might be regarded by the child as an oral-aggressive act, as a deprivation and castration of an essential part of her body, or as a dangerous threat which might lead to the destruction of the child. The child fights against this danger with all her might. As already stated, this is only a partial analysis.

We have little puppets and a small stage on which one child or groups of children can perform their own versions of

the puppet shows. By letting the child be the puppeteer, he is at liberty to add or to delete parts, to repeat scenes he likes, or to create his own original play, which may express his own particular problem much better than the show he saw. The case of Salvatore will illustrate this.

Salvatore, a six-year-old white boy, came to us with the complaint that he would not talk while at school, or that he sat or stood stiffly like an automaton. We learned that this boy, while attending kindergarten at the age of five and a half years, saw the kindergarten teacher disciplining another child. Salvatore became stiff and rigid, and had to be taken out of the kindergarten.

When he entered school half a year later, he again became mute and rigid, and made no educational progress whatsoever. During his stay with us he saw numerous puppet shows. He seemed to enjoy them, although he was somewhat fearful of the alligator. He remained mute whenever an attempt was made to question him. He watched many children perform their own puppet shows, and gradually he formed an attachment to the puppeteer and slowly began to give spontaneous shows of his own. Through repetition he worked out a pattern of dialogue and action, to which he kept rather tenaciously for weeks. With slight variations, his show was as follows:

Mother: Casper, get up and go to school.
Casper: All right, mama.
Mother: First eat breakfast.
Casper: O.K.
Mother: Hurry up! Hurry up!
Casper: Hello, teacher.
Teacher: How much is one and one?
Casper: I don't know.
Teacher: You big dumbbell. *(Hits Casper.)*
Casper: Now I must go to the toilet.
Teacher: You sit down.
The two puppets fight with each other. The teacher is hit again and again by Casper.
Casper: Mama, I have wet pants. Teacher didn't let me go to the toilet.
Casper again beats up the teacher. The teacher hits back.
Casper: All right, mama—I mean teacher. Now we must work.
Teacher: How much is one and one?
The puppets fight again.
Casper: Now, I go home.

One day, while Salvatore was playing, his Bellevue teacher entered the room. The boy immediately became rigid and mute. The teacher went behind the stage, picked up the puppet representing a teacher, and began to play. Salvatore slowly entered into the spirit of the play, and even talked back to the teacher. He became mute again when the teacher tried to speak to him after the show. Through repeated puppet shows, in which his teacher freely participated, Salvatore lost his rigid and mute behavior, and soon began to speak to his teacher outside of the puppet show. He adjusted to classroom routine, quickly picked up his school work, and was returned to his regular school where he made a good adjustment. This is only one instance out of many in which the puppet show helped a child to express his problems and to work them out.

Many complicated emotional problems are basically anchored in attitudes either of love or of aggression. Both of these basic human attitudes can be excellently expressed through hand puppets. Aggression and counter-aggression are forcibly portrayed through fights and the free use of the stick. Love and affection can be equally well demonstrated by letting the puppets dance with each other, kiss, or give presents to each other. These obvious actions are easily understood by all the children. In other words, it is possible to bring even the nursery child to an understanding of complex problems if they are presented to him in a manner that corresponds to his own knowledge and experience. These actions allow for a great deal of repetition. This is understood by the child because it is his own way of experimentation and mastery of things about him. All our shows have a happy ending. We emphasize that the world is not only composed of aggression and hostility, but that there is just as much love and affection around us. A period of conflict is followed by a period of peace and happiness.

In *Casper in Africa* Casper kills the alligator, and in *Rock-a-bye, Baby* he kills the witch. Is it permissible to act out such "cruel" scenes in front of children? Most children are aware of the make-believe nature of the puppet show. They know that the puppets are inanimate objects, devoid of life. The puppets do not suffer real pain when they are hit, and they cannot be killed, because they are not alive in the first

place. The frequent use of make-believe characters, such as witches, devils, ghosts, and giants, allows for make-believe situations on the stage. These features prevent the feelings of fear, guilt, anxiety, or apprehension which the child undoubtedly would suffer if he were confronted with real situations. On the other hand, the absence of these inhibiting forces increases the range of possible play variations. One can go beyond the limitations set by real life and present highly dramatic scenes without running the risk of severely traumatizing the child. Should a child become overwhelmed by a part of the show, one can easily dissolve fears or anxieties by calling his attention to the make-believe nature of the show. To take such a child back-stage and to let him touch the puppets is another convincing method through which these fears and anxieties can be immediately overcome.

Another important point about puppetry is the fact that it is a group activity. This is an economic advantage for a limited staff of people who have to work with large groups of children under certain time limits. The child himself is benefited by the therapeutic agents inherent in group activities. The experiences of the individual become part of the group, and in turn the reactions of the group influence the individual. While he watches the show, the child makes various social contacts and lives through numerous emotional experiences which he either shares with the group or is forced to defend against the opinions of others.

In conclusion, let me say that we at Bellevue Hospital have found hand-puppet shows to be an excellent medium for diagnostic and therapeutic purposes in our handling of children with behavior problems. We have learned to understand the child through his reactions during the play, through his verbal expressions in discussing the show, and through his own puppet activities. The child benefits from these shows because through the puppets he sees himself, other persons, and parts of personalities. The puppet shows give him a chance to react to all kinds of situation. The make-believe nature of the puppet shows reduces feelings of guilt or fear. The frequent repetitions provide for experimentation with all kinds of physical, social, emotional, and intellectual relationships, and finally lead to their mastery. The sharing of his feelings with a group of children has a socializing effect

upon him and enriches his social contacts. All these mechanisms combined enable the child to face a problem, to work it out, and to come to an understanding of it.

Progressive education has long used puppetry as an outlet for self-expression, for group work, and for various intellectual and social purposes. We have gone a step further. We use puppetry as a means of helping the child understand and solve his emotional problems.

EPILEPSY AMONG COLLEGE STUDENTS *

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OUR growing understanding of epilepsy, or the convulsive state, has served to direct increasing attention to its social and personal significance, especially in the case of the non-institutional type of patient. For this reason it was felt that a survey of the incidence and implications of epilepsy, so termed, as it occurs in the college or university setting might be of interest, since apparently no discussion of this aspect has as yet found its way into the literature.

The present report is concerned with students at the University of Michigan who came to the attention of the University Health Service and its mental-hygiene unit over a nine-year period (1930–1939) because of paroxysmal attacks of unconsciousness classifiable as grand- and petit-mal seizures. Particular effort was made to exclude all cases of simple syncope, hysterical reactions, or other unconscious states not possessing the characteristics of epileptic attacks. Cases with a history of convulsions in infancy or early childhood which did not continue or recur up to the college age—incidentally, they averaged some twenty per year—were also excluded.

The total enrollment at the University of Michigan during the nine-year period was 118,532, with a yearly average of 13,170. During this time, a total of 70 students came to attention who were definitely known to be subject to epileptic attacks as described above. Of this number 44 had had attacks before coming to the university, while the remaining 26 had their first seizures subsequent to entrance. Thus,

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roughly, for every five epileptic students in college, two seem to have developed the condition while in residence. Grand mal, with or without accompanying petit-mal seizures, occurred in 64 cases, and petit-mal or narcoleptic attacks only, in 6 cases. As to sex incidence, 50 cases were men and 20 were women. This constitutes a ratio of 2.50 for men to 1 for women, which was slightly higher than that for the university as a whole during the same period (2.30 to 1), and double the ratio of 1.28 to 1 reported for the incidence of psychoses among students at the same institution over a seven-year period (1930–1937).[1]

From our data, the actual incidence of epileptic disorder for the student population is 0.06 per cent. While, of course, our group is too small to serve as a basis for any final conclusions, it is of interest to note that this figure is identical with that given by Patry in a study of epilepsy among New York public-school children.[2] Further, this percentage undoubtedly represents a minimum for the college group, since there is little question that some cases never came to attention, either because attacks were unreported or unrecognized (this is true particularly of nocturnal seizures), or because treatment by outside physicians effectively prevented attacks while the student was attending the university. In view of the small size of this series as well as its limited age range, the incidence as determined for the student body is, of course, not directly comparable to the general incidence of epilepsy, but it may be worthy of mention that it represents less than one-eighth of that (0.5 per cent) estimated by Lennox[3] for the adult population at large.

Meriting comment, too, is the fact that of 44 students who had had frank attacks before coming to the university, 25 gave a history of either "epilepsy," "convulsions," or "fainting spells" on their entrance physical-examination forms. Twelve men and seven women who had made no mention of the attacks at the time of entrance, freely admitted

[1] See "Psychoses Among College Students," by Theophile Raphael and M. A. Gordon. *American Journal of Psychiatry*, Vol. 95, pp. 659–75, November, 1938.

[2] See "The Epileptic School Child," by F. L. Patry. *New York State Journal of Medicine*, Vol. 37, pp. 1553–58, September 15, 1937.

[3] See "Inheritance of Epilepsy as Revealed by the Electro-encephalogram," by W. G. Lennox, E. C. Gibbs, and F. A. Gibbs. *Journal of the American Medical Association*, Vol. 113, pp. 1002–3, September 9, 1939.

attacks and previous therapy after the first seizure in college had occurred. Nine patients reported previous infantile and childhood convulsions.

As to methods of referring cases, 46 students came to the attention of Health Service physicians after the first attack on the campus had occurred, 18 came for examination and treatment on their own initiative, and only 6 were referred by parents, friends, relatives, or home physicians. The small number of cases referred from these latter sources is of special interest. Increased understanding and coöperation on the part of relatives, friends, and physicians are much to be desired and should aid greatly in furthering optimal procedures, not only as regards the question of admission to college, but also, if admission seems advisable, with reference to proper planning and treatment during the college period.

As shown in Table 1, the total number of new and continued cases in attendance each year during the nine-year span varied from 10 to 36, with an average of 21, or 0.16 of the average annual enrollment. Although the number of new cases each year was smaller in this group than in the psychotic, the total number of students with epilepsy in residence on the whole closely approximated the average number of new and old psychotic cases (0.18 per cent).[1] This would seem largely explainable by the fact that the epileptic syndrome, marked by brief discrete attacks, would be less apt to interfere with the academic situation than disorders of the sweeping quality characteristic of the psychoses. So far as can be determined from available records, all but four of the total series had characteristic attacks sometime during their stay in the university, and during each school year an average of 13 students had one or more attacks, which occurred for the most part on the campus or its environs. Among 60 of the group who had one or more grand-mal convulsions, the record indicates that there was an average of at least 21 such seizures during each of the nine years included in this survey.

The ages at which seizures began ranged from birth to 33 years, the average onset for the whole series being 17.1 years and the median 17.0. As is shown in Table 2, there was no significant difference between men and women in the matter of time of onset. The average age of onset for the six cases

[1] See Raphael and Gordon, *op. cit.*

TABLE 1.—NUMBER OF STUDENTS ANNUALLY ENROLLED WHO WERE SUBJECT TO SEIZURES

	Number in residence	*Number who had attacks*
1930–31*	10	9
1931–32	13	10
1932–33	17	13
1933–34	20	7
1934–35	19	9
1935–36	26	13
1936–37	36	24
1937–38	22	13
1938–39	21	15
1939–40†	4	3

* Not including summer session.
† Including only summer session.

who had petit-mal attacks only was 18.6 years. In the aggregate, students who had seizures before coming to the university developed them from four to six years before the group whose attacks occurred after enrollment. The former group includes two in whom seizures had been present since birth, and one each with onset at the ages of five, six, seven, and nine; for the rest the onset was after the tenth year. In this connection, in spite of the smallness of our series, it may be deserving of comment that whereas for non-deteriorated epileptics in general the age of onset has been found to be under 10 years in 25.6 per cent,[1] this was the case in but 11.3 per cent of the college group.

The period elapsing before attacks were noted after enrollment in the university is shown in Table 3. From this it is evident that in the greater number of both new and old cases (over 60 per cent of the total number) the attacks came to medical attention during the first year of residence. The group that had had no attacks prior to enrollment was divided

TABLE 2.—AGE OF ONSET OF SEIZURES IN UNIVERSITY GROUP

	Range	*Average*	*Median*
50 males	1–26	16.6	17.0
20 females	10–33	18.5	17.0
44 with history of attacks before enrollment	1–33	14.6	16.0
26 who developed attacks after enrollment	17–32	21.3	20.0
70 cases (total number)	1–33	17.1	17.0

[1] See "Age of Onset of Epilepsy," by H. A. Paskind and M. Brown. *American Journal of Psychiatry*, Vol. 96, pp. 59–64, July, 1939.

equally between the first and subsequent years up to the sixth. Three known active cases who had been under treatment up to the time of entrance and who continued under medication had no attacks while in residence. Another, not previously under medication, remained free of seizures so far as is known during the two years he was enrolled.

As regards enrollment in the various units of the university, 38 students, the largest number, were from the College of Literature, Science, and the Arts, and 13 from the College of Engineering. Seven were registered in the graduate school, four in law, two in music, and one each in architecture, education, medicine, forestry, library science, and dental hygiene.

TABLE 3.—TIME WHEN FIRST ATTACK OCCURRED IN THE UNIVERSITY

	Patients with history of previous attacks	*New cases*
Within one month	15	2
Within two months	7	0
Within three months	5	2
Within four months	1	3
During second semester	5	6
During second year	4	9
During third year	3	0
During fourth year	0	2
During fifth year	0	1
During sixth year	0	1
No attacks while in residence	4	0
	44	26

The etiological factors, so far as these could be ascertained by complete physical, neurological, and roentgenological studies, are shown in Table 4. As might be anticipated, the cases classified as "idiopathic"—*i.e.*, those in whom no significant causal factors other than constitutional predisposition could be put forward—made up by far the largest group. Organic factors, such as trauma, birth injury, endocrinopathy, congenital defects, encephalitis, and brain tumor, were presumably of etiologic significance in the remaining 18 cases. While the data are admittedly insufficient for final conclusions, the hereditary factor is not prominent in this group of cases. Six students gave a history of seizures among near and distant relatives, one having an uncle and two siblings with convulsions. In the family histories of the other five, attacks

occurred in the case of one father, one mother, two siblings, and one aunt.

With regard to the precipitating factors of individual attacks, in a significant number of cases (at least 15) there seemed to be a fairly definite association with fatigue, irregular habits, overindulgence in alcohol, and special situational stresses, academic and otherwise.

As pointed out by Patry,[1] the therapeutic approach in epilepsy must be directed toward a constructive reintegration of the total personality, which includes competent management of the psycho-affective aspect as well as the specific clinical features related to the attacks as such. The students comprising this series presented a wide variety of personality

TABLE 4.—ETIOLOGICAL FACTORS (EXCLUSIVE OF HEREDITY) IN CASES OF STUDENTS WITH EPILEPSY

	Number of cases
No cause determined ("idiopathic")	52
Onset following severe head trauma	6
Possible endocrine relationship	4
Related to toxic states (alcohol)	3
Residual of infections or inflammations of central nervous system	2
Associated with congenital organic defects of central nervous system	2
Related to brain tumor (meningioma, operated)	1
	70

and adjustment problems and handicaps, and treatment in each case was necessarily highly individualized. Incidentally, all but five of the group were interviewed by members of the mental-hygiene unit. Also, it may be of interest at this point to note that of each hundred cases seen by this unit, approximately one was a student with epilepsy.

As will be seen from Table 5, contacts ranged from cases requiring one or only a few consultations to those at the other extreme with over fifty interviews, the average for the series for the total period being a little over ten per patient.

The situational and personality problems presented by the epileptic students do not differ widely from those found in the general run of college students seen by the mental-hygiene

[1] See "Psychiatric Principles in Educational Methodology with Special Reference to Epileptics," by F. L. Patry. *Medical Times*, Vol. 67, pp. 369–71, August, 1939.

unit.[1] For the group as a whole, however, there appears to be a somewhat heavier weighting with respect to such characteristics as egocentricity, instability, overimpulsiveness, lack of regularity, and poor self-discipline. Also, the number with unsatisfactory academic achievement as a factor is somewhat higher. Feelings of inferiority and pessimism over being handicapped occur frequently and represent a most important consideration in the therapeutic approach. Very essential here is the understanding by the student of his difficulty in factual and non-alarmist terms, and the building up, to the greatest possible degree, of confidence, an open view of the future, and a positive life philosophy.

TABLE 5.—INTERVIEWS IN MENTAL-HYGIENE UNIT WITH EPILEPTIC STUDENTS

	Number of cases	*Total number of interviews*
No interviews	5	0
One interview	10	10
Two interviews	12	24
Three to five interviews	9	37
Six to ten interviews	15	117
Eleven to twenty interviews	11	163
Twenty-one to fifty interviews	5	150
Over fifty interviews	3	229

In at least 48 students in this series there were definite personality maladjustments in addition to the specific epileptic factor. In 35 cases the maladjustment was manifested in pronounced clinical symptomatology, requiring prolonged and intensive psychotherapeutic effort. For this latter group, where adequate therapeutic contact was possible, decided improvement was observed in over two-thirds of the cases. This rather gratifying response serves to reëmphasize the importance of a balanced mental-hygiene approach to the total situation, of which the attacks are but one aspect. That is, it is imperative to bear in mind that in epilepsy as in all medical conditions, we are concerned with living personalities in addition to specific presenting signs and symptoms.

In contrast to the results with these personality difficulties, the outcome in the matter of frequency of attacks was not

[1] See "The Place and Possibilities of the Mental Hygiene Approach on the College Level," by Theophile Raphael. *American Journal of Psychiatry*, Vol. 92, pp. 855–73, January, 1936.

especially encouraging in the majority of cases. The results of medical treatment, so far as these could be evaluated from information available at the end of the nine-year period, are summarized in Table 6. Of 38 students who were observed for a sufficient time to appraise response to the usual therapeutic procedures, such as bromide and phenobarbital medication, dietary regulation, and fluid restriction, 25 remained unimproved and the other 13 showed variable degrees of improvement. In this connection, it should be stated that insufficient coöperation or irregularity in carrying out the prescribed routine was a factor of importance in at least seven of the unimproved cases, the therapy of epilepsy in college being not unlike extramural practice in this respect. With regard to the six cases with petit-mal attacks, one was markedly improved, two reported moderate benefit under bromide therapy, and the remaining three were not observed for a sufficient length of time to evaluate results.

TABLE 6.—RESULTS AS TO FREQUENCY OF ATTACKS AT THE END OF OBSERVATION PERIOD

	Number of cases
Very much improved or apparently recovered	6
Improved	7
Unimproved	25
Indeterminate	32*
	70

* Fifteen because of too short or insufficient contacts; 17 because only one isolated attack was observed.

Also, recent experience may indicate that the use of the newer non-sedative anti-convulsant drugs (diphenylhydantoin derivatives) might prove of more value than previous methods, especially in treating students who object to sedatives on the ground that they interfere with attentiveness in classes and during evening hours of study. Further, clinical experience with our group suggests that the college level of adjustment is a definitely trying one for the epileptic patient and likely to be attended by an increase in frequency of attacks. As evidence of this, in 18 cases who had convulsions of known periodicity before enrollment and who had three or

more attacks while in residence, the frequency was doubled in six, variably increased in five, and continued unchanged in seven.

As to the academic averages [1] of the group, up to the close of the period observed, 37 were satisfactory, 13 were fair, 13 were unsatisfactory, and 7 did not remain in the university long enough to secure credits. Of the six students who had petit-mal attacks, only one was unable to continue because of poor scholarship.

TABLE 7.—UNIVERSITY STATUS OF STUDENTS WITH EPILEPSY AT THE END OF THE NINE-YEAR PERIOD

	Number of cases
Graduated	30
Continuing in the university	13
Not at present in attendance, but with no actual contraindication to same on basis of university requirements	9
Unable to continue in the university	18*
	70

* Four because of markedly increased frequency of attacks; 6 because of epilepsy and scholarship; 7 because of scholarship or other administrative reasons; and 1 because of death (status epilepticus).

The final outcomes with respect to university status through the first semester of 1939–40 are shown in Table 7. As would be expected, a higher proportion of these patients graduated or could continue in college than in the psychotic group, the figure actually reaching 74.3 per cent, as compared to 49.1 per cent for the latter. Thus in selected instances, and especially under adequate care and management, epilepsy, or the convulsive state as such, seems by no means inconsistent with satisfactory college or university performance. In addition, it should be emphasized that close and intensive attention may be especially significant in the college situation because of the age factor and the long period available for observation and treatment. In this way, much may be accomplished not only as to the establishment of a proper therapeutic formula for the attacks as such, but also, and perhaps more important, with reference to the

[1] Based on the following scale: satisfactory, C+ and over; fair, C to C+; unsatisfactory, below C grade.

constructive orientation of the individual patient to himself, his condition, and life, a point of critical moment for future adaptation and effectiveness.

Finally, with regard to the convulsive state, as to medical conditions generally, the fullest and most open coöperation with the college is urged upon prospective students, their families, and their medical advisers, as opposed to the inadequate understanding, reticence, and even actual concealment that seem to a significant extent still to obtain. Obviously, only through frank, collaborative, and professional facing and evaluation of the situation can the best good of student and college be served. In cases in which admission does not at the time seem a constructive measure, such collaboration might at least lead to a fuller appreciation of the individual situation and a determination of the plan of procedure best suited to the case as it stands. And for those admitted, adequate treatment and planning as to the college program, both curricular and extracurricular, would thus be made possible from the very beginning of the college period, a matter of considerable practical import.

Further, in the college situation, as in other social relations, it is essential that it be realized that the element of stigma traditionally attached to epilepsy has no place in any modern valid conception of the disorder. In other words, the convulsive state must be envisaged simply as one medical condition among many others, to be appraised upon its clinical merits, broadly conceived, and not of necessity as constituting a bar to positive college performance. Such a view on the part of colleges and universities would do much to encourage that fuller and franker coöperation by students, their relatives, and their physicians so essential for adequate evaluation and procedure.

G. ALDER BLUMER

A great scholar and an earnest friend of mental hygiene has gone from our midst, and The National Committee for Mental Hygiene wishes to spread upon its records an appreciation of the life and work of Dr. G. Alder Blumer.

Dr. Blumer was a leader in the early days when the founder of the mental-hygiene movement, Clifford W. Beers, was urging the abolition of mechanical restraint and better hospital care. His championship of greater liberty for individual patients, of the development of occupational therapy, and of many other causes favoring the humanitarian and scientific study and treatment of mental diseases won him the gratitude of all friends of mental hygiene throughout the world.

Back of this leadership was the mind of a scholar. This was demonstrated in his outstanding work in the field of psychiatry and in the fostering of all types of medical as well as of civic progress. He was a prolific writer and a master in the use of English. Conversation was an art with Dr. Blumer, and it was a privilege to bask in the fluency and aptness of his expression.

Beyond his scientific leadership and his scholarly attitude was the personality of a warm friend and a courtly gentleman. Sympathetic in understanding and sensitive to the interests of his fellows, his approach to friendship was delightful. One left his presence lifted to a higher plane of thought and feeling.

The National Committee for Mental Hygiene wishes to acknowledge with deep gratitude the important part that Dr. Blumer played in the advancement of psychiatry and mental hygiene, and to express our continuing gratitude for the contribution that he has made as leader, scholar, and friend of our work.

ARTHUR H. RUGGLES.

BOOK REVIEWS

PSYCHIATRIC CLINICS FOR CHILDREN: WITH SPECIAL REFERENCE TO STATE PROGRAMS. By Helen Leland Witmer. New York: The Commonwealth Fund, 1940. 436 p.

This book by Dr. Witmer is based on data on state-wide psychiatric services for children that were assembled by Miss Winifred Arrington and Miss Dorothy Brinker, of The National Committee for Mental Hygiene. To imply, however, that these data are the sole basis of the book would do a serious injustice to the author, who brings to an analysis and evaluation of this material a wide knowledge of the theoretical basis for psychiatric clinics for children and a thorough understanding of the influence of cultural settings upon the effective operation of such clinics.

This is not just another survey. The author has succeeded in taking extremely heterogeneous data regarding state-supported psychiatric clinics for children and giving them meaning by placing them in a perspective of psychiatric theory, social setting, and historical development. But this is by no means the full contribution of the book. On the basis of the material and the perspective developed, Dr. Witmer has arrived at certain principles for the development of future programs which should receive careful consideration by any one who is planning a clinical program for children, or, for that matter, any one who is now conducting such a program.

The book is divided into three sections. The first part is concerned with the background of psychiatric clinics for children. The second part deals with the material obtained from a survey of state-financed psychiatric clinics. In the third section, the author formulates some general principles and criteria for the future development of clinical programs.

With respect to the three chapters that make up the first section of the book, it is difficult to be critical, because one realizes that they serve merely as a background for the subsequent material. No one, for example, could be expected in the space of one chapter to cover more than the major trends in psychiatric theory. However, some may question the emphasis placed by Dr. Witmer on the contribution to psychiatric theory of Meyer as compared to that of Freud. No one can question the tremendous influence of Adolf Meyer on the development of psychiatric programs of all sorts, including psychiatric clinics for children. But while William A. White is mentioned,

with others, as having influenced the development of psychiatric service to children, his major contribution is not indicated. It seems probable that White, whose concepts of "the organism as-a-whole" are similar to those of Meyer, and who accepted Freudian theory as well, did more, perhaps, than any single psychiatrist to educate the general public to the meaning of these concepts, and thus to prepare the way for the acceptance of psychiatric clinics for children by parents as well as by professional workers.

Every organization operates within the framework of its social setting and the psychiatric clinic is no exception to this rule. Too often the hospital physician, who has his patient isolated from society, treats him with but little reference to the social implications of the case. When he brings this lack of understanding of social attitudes and social facilities to the treatment of children, any efforts he may make in the treatment of their problems are bound to be futile. Likewise, an evaluation of the objectives of a clinic program and the results of that program must take into consideration its social frame of reference. Dr. Witmer provides this social setting of the psychiatric clinic by a brief discussion of the more salient attitudes with which the clinic has to deal. Following this is an historical résumé of the development of psychiatric clinics for children up to the present time. Of most significance, so far as state-financed clinic programs are concerned, are the development of the combination of social worker, psychologist, and psychiatrist as a clinic team, and recognition of the fact that cities with populations of less than 200,000 are unable to support and utilize full-time psychiatric clinics for children.

The opinion is reached that if the contribution of child-guidance workers is to be made available to children outside of metropolitan areas, it must be by the extension of state-financed clinics. Before this can be done, it is necessary to appraise the present state-financed programs and also to reach a clear understanding of the nature of child guidance. The first of these procedures is carried out in the second section of the volume, which is a survey of state-financed clinics.

Because of the heterogeneity of these clinics, it proved difficult to classify the material assembled by The National Committee for Mental Hygiene. The basis for classification finally chosen was found in the administrative authorities under which the clinics operated. There are detailed descriptions of clinics for children as operated by state hospitals, by psychopathic hospitals, by state departments of mental hygiene, and by state welfare departments. These are analyzed as to origin, objectives, difficulties encountered, the types of patient served, time spent and number of patients seen, type and

effectiveness of treatment, and composition and training of staff members.

The conclusion is reached that the clinics conducted by state hospitals have not been very successful. There has been opposition on the part of the community to taking children to such clinics, because of the prevalent attitudes toward mental disorder. The clinics in general have not been adequately staffed, nor has the personnel been adequately trained for psychiatric work with children. Work has tended to be diagnostic, and the types of case seen are usually the mentally defective or the neurologically handicapped.

The psychiatric clinics operated by central state departments have in certain instances done better work with patients, but the two purposes for which they were developed have not been realized—namely, the stimulation of local communities to assume responsibility for such work, and the development of psychiatric clinics for children by the various state hospitals. As demonstrations and from the point of view of education, there is little evidence of their success. On the basis of the data given, these general conclusions seem warranted.

In the third section of the book, the author develops certain principles for the development of future programs. With the majority of these one can agree, and their significance is such that no one planning a psychiatric program for children should fail to give them serious consideration. There are, however, one or two points on which there may be disagreement. In order to create a basis for the formulation of such principles, the author analyzes the objectives of psychiatric clinics. These are stated to be (1) the prevention of institutionalization, (2) the prevention of mental disorder, and (3) the treatment of children's problems for their own sake, without reference to any future outcome. The author believes that the first and the last are satisfactory and realizable objectives, but she would discard the second. Her reason is that there is no evidence to indicate that it is possible to identify the children who will later develop psychoses. While this is true in most cases, it would not seem a satisfactory reason for abandoning this objective. This reasoning is based on a descriptive rather than a dynamic psychiatry, and is unusual for this author, whose whole volume is a condemnation of a static, descriptive, diagnostic type of clinic. It may be said also that in public health in general many preventive procedures are undertaken—such as vaccination, for example—even though it is not possible to predict the future infection of any particular person. It is not necessary to identify the future psychotic in order to do a preventive piece of work. Many of the other objections that the author raises hinge on this matter of attaching labels.

This point may be a very important one for state-financed clinics,

as the securing of support for them will very likely depend on this objective as well as on the objective of the prevention of institutionalization. This applies equally to the development of such clinics as a public-health program, which the author sees as a desirable step.

Proceeding on the assumption that there are two valid objectives, the author then states that a clinic should choose one or the other. She does say that they are not mutually exclusive, but her major emphasis is on a staff organization and a training of personnel directed toward one or the other of these objectives. The implication is also strong that the state-financed psychiatric clinic will be engaged primarily in the prevention of institutionalization while the urban child-guidance clinics will be concerned with the treatment of children's problems for their own sake. While there is much to criticize in state-financed children's clinics, urban child-guidance clinics have often been so restrictive in their intake that they have limited themselves to certain children with good prognoses, leaving the mentally, physically, and seriously socially handicapped children to be dealt with by other community agencies. It is questionable whether psychiatric clinics for children should become so specialized that a particular type of clinic will be available for each kind of psychiatric problem. The objective should rather be that of providing both urban and rural clinics with staffs that will be quantitatively and qualitatively able to meet the needs of the population served. After all, there are many mentally defective and neurologically handicapped children in metropolitan areas.

In considering psychiatric service for feebleminded and neurologically disabled children, as well as those emotionally disturbed, the author very forcefully brings out the different needs of these patients and shows how they must be met in any future program. However, she uses the term "psychiatric treatment" in a very narrow sense. She would seem to limit it to psychotherapeutic interviews. Psychiatric treatment would seem to be much broader than this—broad enough to include any program of treatment that is based on adequate knowledge, whether it deals directly with the patient or with his family or social environment.

Considerable attention is paid to the basic psychiatric principles involved in the planning and operation of a psychiatric clinic for children. The author is rightly concerned with these, as they materially affect the work done in any clinic. These various theoretical concepts are well handled, particularly as they affect clinic practice. There is a question, however, as to the emphasis placed on what may be called "late Rankian" concepts. This is not the place to argue the merits of these concepts, but it is doubtful whether they have had the importance for clinic practice that is implied. It is true that

they have met the needs of many social workers, particularly those in non-psychiatric agencies, but with the exception of a few clinics, they have not formed the major basis of orientation of the psychiatrists.

The author discusses the various auspices under which future state-financed clinics may be developed. She expresses considerable doubt as to the feasibility of using the state hospital as a source of psychiatric help to children. There appear to be difficulties also in the operation of such clinics under the auspices of schools or juvenile courts. Two other types of clinic are discussed—namely, those under the auspices of state welfare departments and those conducted by state health departments. The objection to the first type is its association with poverty, and the tendency to use such psychiatric service for the wards of the state only. Sound reasons are given for the desirability of developing psychiatric clinics for children as a part of a public-health program. It is the only type of state-wide agency that serves the whole public without reference to economic or social status. The chief difficulty is the philosophy of treatment versus prevention that has prevailed in the past. The logical arguments are answerable in terms of a dynamic approach, and there is evidence that an actual change of attitude is in process.

That the conclusions as to the feasibility of developing psychiatric clinics under public-health auspices are sound has been amply demonstrated by the program of the Connecticut State Department of Health. For nine years this program was primarily educational; then for six years it was a program of the usual traveling diagnostic clinics for children. Since 1935, however, it has been reorganized to bring a treatment type of service into smaller communities. Actual experience confirms the criteria that Dr. Witmer has set up as necessary for the formulation of state-financed clinical programs. Limitation of the service to a population of from 40,000 to 50,000 for each full day of clinic service, repeated in the same clinic each week, augmentation of the social-work staff so that it can do more of the social work in the smaller communities, properly qualified personnel, and recognition of the objectives sought, have all been verified as valid criteria. Experience has also shown that public-health work seems to offer a situation favorable to acceptance by the public of psychiatric service for children.

This volume of Dr. Witmer's meets a real need in this country. The orientation of the author, her presentation of the material of the survey, and the conclusions drawn shown a high degree of objectivity. The significance both of the material and of the conclusions is such that no one planning a program of psychiatric clinics for children can afford to ignore it. Furthermore, as a basis for evaluating the present work of varied programs of this sort, is in invaluable.

It should also be useful to those staff members who work both in urban and in rural types of clinic in helping to orient them to their function in the total objective of bringing psychiatric service to children. Educators, probation officers, and others will also find in this volume much that will aid them to appreciate the function of psychiatric clinics in relation to their own programs.

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AS THE TWIG IS BENT. By Leslie B. Hohman, M.D. New York: The Macmillan Company, 1940. 291 p.

We have here a book that is written for parents, and with a definite aim in view. This aim is to awaken the fathers and mothers of children to a realization of their responsibilities in the formation of the later personalities of the unspoiled babies that are born to them. With this end in mind, the possibilities of constitutional factors are definitely minimized. This is as it should be. Parents are far too prone to shift the responsibility for their mistakes with vague excuses about the inheritance or original nature of their sons and daughters.

It is undoubtedly for this same purpose that the author builds his whole exposition upon a basis of habit-training and conditioning. Several passages suggest that he is sympathetic with an adequate understanding of unconscious dynamic factors, but that he considers a study of them of slight value to parents in matters of child training. This point of view seems to be amply justified by the book that has resulted from it, a book that presents the requirements for the adequate training of children in a clear and understandable way.

The book begins with an exposition of the need for constructive training, together with an attempt to break down such popular fallacies as the idea that a child will outgrow his bad habits. Then follows a discussion of the simple mechanisms by which behavior is acquired, with some well-placed emphasis on the thesis that bad habits thrive on attention and wither under neglect. Dr. Hohman clearly advocates a middle course between the rigid discipline of former days and the ultramodern method of allowing children unrestrained expression of all their impulses. His criticism of the latter trend is carefully worked out. He believes that the damage done to the personality by a certain degree of restraint, even of the strongest and most fundamental drives, is not so great as many writers have made it appear to be. Such an attitude is a very healthy one in this day and age.

The major portion of the book is taken up with the application of rational principles of habit-training to such phases and problems of child life as activities, work, illness (both real and fancied), temper

displays, fantasy, untruthfulness, fears, jealousy, dependence on parents, and psycho-sexual development. Each of these topics is treated clearly and lucidly.

There are two features of the book that might cause the physician to hesitate a little about putting it into the hands of parents. One is the author's rather undue emphasis upon a particular method of treatment. Rolling a child tightly in a blanket and pinning it up until the emotional expression of the moment has subsided is a procedure recommended in several places. It is doubtful whether all psychiatrists would agree to so drastic a measure in the handling of night terrors, for example, or would wish laymen to read of such a procedure, which they might easily misunderstand and misuse. The other difficulty is the type of example used. Not all of our patients (none in a publicly supported clinic) come from homes in which there are butlers and nurses, and which are financially able to send the children to private schools. The general usefulness of the work would have been greater if Dr. Hohman had had a less wealthy clientele.

These objections, however, are minor. They are far more than outweighed by the clarity, moderation, and general readability of the work. We have to-day far too few books on mental hygiene that are suitable for the layman. Too frequently, a book ostensibly written for this purpose is too involved and technical, lacks sufficient constructive suggestions as to what should be done as against what should not be done, or tends to emphasize one cult or school of thought. Dr. Hohman has avoided these pitfalls. In doing so, he has made a worth-while contribution to our field.

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PROCEEDINGS OF THE CHILD GUIDANCE INTER-CLINIC CONFERENCE OF GREAT BRITAIN, 1939. London: The Child Guidance Council, 1939. 136 p.

This booklet reports the Fourth Biennial Child Guidance Inter-Clinic Conference held in London on January 27 and 28, 1939. Six topics are covered: "Treatment of Parents," "Juvenile Delinquency," "Personality Deviations and Diagnosis of Psychoses," "Scope of the Educational Psychologist Working in the School," "The Psychiatric Social Worker as Interpreter of Treatment," and "Substitute Homes."

A great many important and interesting points are brought up. For example, in the discussion of treatment of parents, references are made to situations in which parents are unconsciously opposed to improvement of the child's condition and in which such improvement,

if it occurs as a result of treatment by the clinic, may aggravate the parent's own problem, which before had been more or less concealed through expression in the child's symptoms.

In the section on delinquency, sociological and individual psychological factors are taken into account from the standpoints of etiology and therapy. A proposed inquiry into juvenile delinquency is described which does not seem as penetrating or as far-reaching as the American studies by Healy and Bronner,[1] in which non-delinquent siblings were also studied as controls.

The discussion of personality deviations and diagnosis of psychoses is a technical one for the psychiatrist.

Several interesting projects are described in the section on the work of the educational psychologist, such as the special classes "for children under seven retarded, not for reasons of any dullness, but usually for reasons of some emotional kind."

There is a thoroughly practical discussion of the difficulties the psychiatric social worker meets in interpreting treatment to the family, the school, other social workers, courts, and probation officers.

In the consideration of substitute homes (foster homes), the need for caution is very rightly stressed. Placement, it is emphasized, is never to be undertaken lightly; from the child's standpoint, it is never a simple procedure; it may mean rejection, even when it is not supposed to, and may be the cause of feelings of guilt and so forth; and, finally, it may involve definite risks.

On the whole, the presentations are clear, concise, practical, and interesting. They are, of course, necessarily brief and rather general.

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DO ADOLESCENTS NEED PARENTS? By Katherine Whiteside Taylor. New York: D. Appleton-Century Company, 1938. 380 p.

Many books have been written on the subject of adolescence. All of them attempt to give us an understanding of the physical, intellectual, and emotional changes that take place in the child at this difficult time of life. All of them consider the problems that are apt to arise, and the various means that may be used to treat them. The particular emphasis of each book on the subject naturally depends on the training and special interests of the author. Physicians, educators, psychologists, psychoanalysts, all write from their own special points of view.

Dr. Katherine Whiteside Taylor has been director of a nursery school, has brought up three children of her own, and has done

[1] *New Light on Delinquency and Its Treatment*, by William Healy and Augusta Bronner. New Haven: Yale University Press, 1936.

a great deal of mental-hygiene work in clinics devoted to the problems of child-parent relationships. At present she is Chief of the Division of Prevention, Department of Mental Hygiene, State of Wisconsin.

From the author's qualifications, one would expect that her approach in a book of this sort would be that of the practical individual who is constantly faced with the many problems of adolescence and is forced to do something about them here and now. Dr. Taylor fulfills these expectations to an admirable degree. Her book is, however, far more than a guide as to "what to do when." The thoroughness with which she surveys and discusses the entire field of adolescence bespeaks years of careful preparation. One cannot but be impressed by the innumerable quotations that enliven and enrich the book. By actual count, they average one or two per page, and many of them are quite long. If this book were considered only as a compendium of valuable quotations on the subject of adolescence, it would still serve a very useful purpose. But the author has been able to link these quotations together with material of her own in a manner that adds considerably to the worth of the book. In many places original data from the Hanover Outline on Personality and Culture are inserted to lend authority to the work.

One might subject a number of changes that would merit consideration in a second edition. The title, for example, seems a little whimsical. *Adolescent Years,* or simply *Adolescence,* would seem more appropriate and dignified. The outline on which the book is presumably based is in places carelessly followed. Part I is entitled *The Parent's Rôle;* Part II, *Adolescent Needs.* Yet the first topic, discussed for several pages, in the first chapter of Book I is headed, *The Adolescent's Needs.* Another topic in Chapter Two of Book I is entitled, *Do Adolescents Need Guidance?* By page 69 the author is again going along well, sticking to "The Parent's Rôle" (and doing a splendid job of it) when suddenly she starts a new section with the title, *What is Adolescence?* The topics that follow are: *Adolescence is a Process, Cockiness, Growth is Uneven, Adolescents are Individuals, Treatment Suited to Development Levels, Awkwardness, Extreme Variations, Voice Changes, Complexion Ills, The Need for Reassurance, Preparation for Puberty, Bodily Changes, Essential Facts, New Emotions, Parental Attitudes, Masturbation, "'Puppy' Love," First Love, The Jilting.* All these topics are treated in a masterful fashion, yet they follow one another without rhyme or reason. The reviewer, a male, is tempted to say that Dr. Taylor writes as many women talk—with brilliance, charm, and wit, but with a magnificent disregard of logical understructure.

A more serious criticism has to do with the author's demonstration of that limited amount of medical knowledge which may well be called "a dangerous thing." In her discussion of variations in body weight and height, her enthusiasm for "glandular therapy" is entirely uncalled for, and her statement (p. 81) that "even moderate variations if disturbing to the young adults may be alleviated by this type of treatment" is quite misleading.

The reviewer wishes to emphasize, however, that despite the objections raised above—and these could easily be obviated—Dr. Taylor's book is a real and valuable contribution in the field of adolescence. The reviewer has already taken several occasions to place the book in the hands both of adolescents and of their much-needed parents.

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LOVE PROBLEMS OF ADOLESCENCE. By Oliver M. Butterfield. (Contributions to Education, No. 768.) New York: Teachers College, Columbia University, 1939. 212 p.

The reviewer recommends this volume to parents and teachers as a source of mature and competent opinion on the love problems of adolescence. Critical students, however, will be disappointed in it as a contribution to new knowledge of these probems as felt by or reported by adolescents themselves.

One of the essentials of a good piece of research is the collection of adequate data. Adequacy of data may be tested by several criteria, among them relevance and objectivity. It is just at this point that most studies of sex problems encounter difficulties. The present study is no exception; indeed, the difficulty is aggravated because it is not appreciated.

On the one hand, Butterfield collected anonymous questions written on blank cards by over seven hundred boys and girls, aged from thirteen to twenty-five, prior to group meetings and discussions of their love problems. Unfortunately, the exact setting of these group meetings and the nature of the instructions under which the questions were written are not specified. Such data are clearly relevant to the problem, but are far from objective. No analysis of these data is presented.

On the other hand, Butterfield prepared six different check lists of love problems which were used with nearly four hundred individuals prior to group discussions. These data are objective (in the sense that check marks can be counted without subjective error), but there is no evidence concerning their relevance beyond the bare

assertion that the check lists were prepared on the basis of the spontaneous anonymous questions.

The analysis of these data is necessarily superficial since even such elementary facts as the age and sex of the individuals who responded to the check lists were not ascertained. The title of the volume might better have been *Expert Adult Opinion Concerning the Love Problems of Adolescence,* since a large proportion of the space is given to a discussion of these problems from an adult point of view. The original data are mediocre; the discussion is excellent.

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THE ORGANIZATION AND TEACHING OF SOCIAL AND ECONOMIC STUDIES IN CORRECTIONAL INSTITUTIONS. By Glenn M. Kendall. New York: Teachers College, Columbia University, 1939. 159 p.

This book has a wider appeal than its title might indicate. Not only teachers in correctional institutions, but those interested in social and vocational education at all levels will find it valuable. Written by the Assistant Director in Charge of General Education, of the Department of Correction, State of New York, it is somewhat singular among books about education in that it is neither flooded with fanciful ideas nor dulled by facts reported without discussion of their relations and implications. Dr. Kendall sees his problem as a whole; he offers no panaceas; he wears no rose-colored glasses. What he does present is a realistic consideration of prison education and a plan for prison schooling based on experience in several institutions—a plan wherein vocational and social education are closely and cleverly correlated. The correlation of education and socialization is even more apparent in the correctional institution than in civilian life.

The first four chapters contain background material helpful in understanding the teaching materials and methods later described, which were developed in the course of an experimental project carried on at Wallkill Prison in 1935–36. These are some of the subjects treated in the first chapters: the development of correctional education (particularly in New York State); the function of social studies in correctional institutions; a psychology of learning; and prisoner attitudes.

Then follows an account of the Wallkill experiment. After a careful appraisal of inmate attitudes, the Wallkill teachers selected four broad problem areas—namely, "America at Work," "Getting Goods to People," "Housing America," and "Wheels of Progress —a Study of America's Transportation System." Particular prob-

lems and corresponding study units were set up. Discussion was the teaching procedure most frequently used, and a great deal of teaching was done through the largely vocational class activities. About half the book is devoted to descriptions of eight illustrative social-study units.

Dr. Kendall would have his teachers remain as objective in their approach as possible, although he recognizes the value of a teacher's occasionally taking sides. He states further (pp. 10–11):

> "The viewpoint in such teaching must be both realistic and optimistic. The only rational position which correctional teachers in this field can adopt is to accept conditions as they are, admit injustices and maladjustments where they exist, interpret causes as accurately and objectively as possible, and stress opportunities which do exist and efforts which are being made to correct bad conditions."

To admit injustices and accept conditions as they are, to be realistic and optimistic, are difficult jobs, particularly in correctional institutions.

One has some doubt concerning the effectiveness of this measure, in view of the tremendous difficulties that attend it. Nevertheless, the Wallkill plan seems to have met with reasonable success, as measured by inmate interest. How well former students have fared we do not know. Undoubtedly, follow-up records and comparisons are being made. The author reports considerable expansion of social-study teaching in other New York State correctional institutions since the experimental work ended. At Wallkill the work is being carried on "with much enthusiasm and success."

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The American Criminal: An Anthropological Study. By E. A Hooton. Cambridge: Harvard University Press, 1939. 309 p. plus appendix.

For a long while it has been known by those in contact with Professor Hooton that he has been engaged in statistical work on the comparison of criminals with non-criminals. Naturally, the published results of this work, in this first of the three large volumes that are promised, will be eagerly examined.

In order to understand the morphological peculiarities of criminals as a class, it is necessary to have a base line of controls, deviations from which will give the information sought. Accordingly, Dr. Hooton arranged for the measurement of such controls. The present study embraces only the native white criminals of native parentage. Apparently about 5,000 of such males, from ten states of the Union,

were measured. There were also 313 native whites in civil life, these latter from two states, Massachusetts and Tennessee. The Massachusetts controls consisted, in part, of the personnel of militia in armories and, in larger part, of out-patients of the Massachusetts General Hospital, as well as out-patients of the Beth Israel Hospital. These controls were apparently largely of foreign stock. In Tennessee the controls consisted of 146 Nashville firemen. It may be noted in passing that these firemen from one city are probably as different from the Tennessee population at large as are the criminals. Apparently no attempt was made to determine how far the selected firemen differed from the general population.

The measurements taken and observations made were 52. Nineteen measurements were taken on the head and face. Other measurements were of weight (apparently with shoes, for which, and other clothing, three pounds were subtracted), stature, shoulder breadth, chest depth, chest breadth, and sitting height, 13 indices being calculated from these data. In addition, observations were made upon hair, including facial hair; skin and eye color; eye folds and facial and cephalic traits that could not be easily expressed quantitatively; also teeth, ears, neck, and shoulders.

The data brought in from the field by two observers (known anonymously as A and B) were sent to the statistical room, where data were punched on Hollerith tabulating cards and put through an electrical sorting and tabulating apparatus of the Hollerith type. The means and probable errors were computed, and the tables thus prepared were laid before the author of this book.

In addition to the individual traits measured and observed, information was secured on occupation, religion, offense, previous conviction, education, race and parentage, marital state, and offspring. In a limited sample of Massachusetts prisoners, some intelligence quotients were obtained. These sociological data seem to have been secured from institutional records. It may be added parenthetically that any one who has compared institutional records with the facts obtained from a study of the families at home will realize that they are so full of misstatements as to be practically worthless. This does not necessarily apply to the data on "previous offenses" or possibly to those on "occupation," but it probably does apply to statements as to education, race and parentage, and even marital state and religious affiliations. The offense for which the subject was incarcerated was copied from the prison records, and ten categories in crime are the principal basis of the comparative statements concerning morphological peculiarities of criminals that occupy a large part of the book.

The results of the Hollerith tabulations are presented in a number

of tables, partly scattered through the text, but mostly included in the electrotyped appendix. The total number of these tables is difficult to compute precisely because some of them are divided up into as many as 148 subdivisions. They occupy, however, a total of one and a fourth inches thickness of paper at the back of the book and by estimate about three-fifths of the whole volume. The pages are not numbered, but as the tables are arranged in a numerical system, it is not difficult to find a given table.

The main body of the text consists of a general account of the present survey, including the sociological data, the metric and indicial differentiation by states, the morphological differentiation by states, the anthropometric and indicial differentiation by offense groups, the morphological differentiation by offense groups, the differentiation by occupation and by body-build types, the morphological offense types, the differentiation between criminals and civilians of similar parentage, and some 60 pages of summary and conclusions.

Naturally, this monumental work contains a vast amount of information that will be eagerly examined by sociologists and anthropologists. There is no question about the value of many of these data.

The author's conclusions are important and perhaps the final sentence summaries the whole two volumes: "Crime is the resultant of the impact of environment upon low-grade human organism. It follows that the elimination of crime can be effected only by the extirpation of the physically, mentally, and morally unfit, or by their complete segregation in a socially aseptic environment."

It remains to examine in more detail the material offered in order to judge in how far the conclusion, which might have been reached *a priori*, is supported by the data.

First, it is necessary to make certain criticisms. The plan of the research may well be open to criticism. Thus, in attempting to get at the difference between criminals and normals, the normal base line from which the deviation of criminals is, as it were, measured is a very insecure and unreliable one.

Second, necessary as it may have been, in order to secure sufficient data, to employ two observers, yet it cannot but be considered as unfortunate that this was necessary because of the personal equations involved, which, in dealing with small differences, are often greater than these differences themselves. Dr. Hooton has, indeed, recognized that in two or three of the organs measured the observers showed strong personal biases which made impossible the blending of their results. It seems highly probable, from the experience of others, that many other measurements had a similar, though perhaps smaller and therefore undetected, bias.

Third, while the tabulations were conscientiously made, they seem

to be unnecessarily diffuse. One learns, for example, from Table II–14 that 100 per cent of the Belgian-American criminals were Catholics. One might draw from this an inference concerning the effect of that sect in producing criminals unless one noted that the total number of criminals in this category is one. Altogether, there are six extractions that contain only one person each. The U. S. Census would probably relegate these to one class of "others."

The results of the tabulations, as drawn by Dr. Hooton, are given in the chapter on general conclusions. He finds, *inter alia*, that first-degree murderers show an excess of median chins and a deficiency of bilateral chins; whereas second-degree murderers have a deficiency of median chins and an excess of bilateral chins. This sample of the conclusions drawn raises at once several questions, such as, What is a first-degree murderer, and how does he differ from a second-degree murderer? Whether a given murderer shall be placed in the category of first or second degree depends upon a great many things. First, upon what the murderer did; second, upon the efficiency of his lawyer in securing a first- or second-degree classification; third, upon the nature of the jury and the extent to which they were impressed by the defense attorney; fourthly, upon the nature of the judge and whether he had a special liking or distaste for median chins. Since so many things enter into the final classification, it is remarkable that there should be strong morphological differences between the criminals which lead them to fall into one or the other of these two classes of murderers. I know that Dr. Hooton might well say, "This is what we found, and the difference is 4.5 times the probable error." On the other hand, one thinks of a statement attributed to the late Thomas Huxley, to the effect that when a man says he saw a white horse on the street, we accept his statement without registering doubt; if he says that he saw a green horse on the street, we require more evidence. And so the difference between excess median chins and deficient median chins can hardly be accepted as significant without further examination, even though the difference may be 4.5 times the probable error.

Speaking of probable errors, the tables are very full and complete in this respect. To take a table at random, VI–12 gives, for blue-brown eye color, the difference between percentage incidence in second-degree murderers and criminals in general. This difference is 3.32 times the probable error of the mean and is, therefore, to be regarded as significant. But the difference in the incidence of this trait between any of the other nine classes of criminals and criminals in general is not over 2.5 times the probable error. Are we, then, to conclude seriously that second-degree murderers alone differ from criminals in general in percentage incidence of blue-brown eye color

(however that may be defined)? For example, first-degree murderers and assaulters show no such difference. Is this a biological result or is it because the observer in Tennessee (where the percentage of "second-degree murderers" is assigned to a proportionally large number of criminals) made a specialty of calling eyes blue-brown rather than calling them, as did the observer in Massachusetts, light-brown, or green-brown?

Criticism may be directed toward the non-quantitative morphological data, such as amount of hair on the head, skin color, hair color, eye color, and so on. One knows that prisoners are often close cropped, whereas Nashville firemen are perhaps not. Hence it will be difficult to compare the amount of hair in the two groups; and if these comparisons are made independently by different persons, the comparability of the results becomes less probable. The trait of skin color is divided into eleven categories, and the observers were supposed to be able to differentiate correctly between light yellow-brown and medium yellow-brown; also between red-white and ruddy. In the matter of hair color, they were supposed to differentiate between light brown and ash brown, between black and dark brown. In eye color they were supposed to differentiate black, light brown, brown, grey-brown, green-brown, blue, and grey. These eye colors are nowhere defined in the volume, and even to one who has had considerable experience over many years in observing and recording hair and eye color, the terms mean very little. Certainly no person can confirm or disprove the findings in this volume in respect to eye color in criminals as compared with the standard population by making observations of his own, since it is certain he would not use the terms in the same way as the observers A and B did.

Again, the subject of the morphological differentiation of criminals from the general population is one that has already been the basis of considerable research. On page 15 Dr. Hooton refers to a number of researches made by criminal anthropologists, and some of these had very large numbers of controls. For example, Marty examined 4,500 criminals with respect to general bodily proportions and 10,000 civilians used as controls. Yet I do not find that the results obtained from Dr. Hooton's researches are anywhere compared with the results obtained by Marty. In fact, Hooton's book makes few references to the work of others. Lombroso's work, which was crude and observational, is referred to, as is that of Goring, an author who is undoubtedly prejudiced. And two or three statistical books based on measurements of Americans are cited, but no general attempt is made to compare the results given here with those obtained by others. There is, indeed, no bibliography in the work, so that one is given no insight into the literature of the subject.

Another unfortunate lack is that of a list of tables in the appendix. Certainly, it would help the student to be able to find quickly, through such a list, the tables relating to particular topics.

I have said enough in the way of criticism. I revert to my original earlier statements that the work is in general valuable and there is much in it that is significant. The defects of the work arise from the fact that the author was not the observer—that, sitting at his desk, he was provided with the tabulated sheets by the Hollerith operators and wrote his book largely from the means and probable errors, computed by their machines. The result is a mass of conclusions which are not as critically examined and defended by the author as they would have been had he made the observations himself. He relies too much upon the machine work and seems at times lost in the maze of the vast number of tables. These lead him into many blind alleys; he has difficulty in distinguishing the really significant from the less significant byways. He emerges where he started—with the conclusion that criminals are probably, in some respects, morphologically unlike the mass of the population from which they are drawn.

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The Functions of the Executive. By Chester I. Barnard. Cambridge: Harvard University Press, 1938. 334 p.

A distinguished business executive here attempts to untangle the psychological complexities of coöperation (and organization) and to describe the executive in the light of this analysis. Recording that there are more formal organizations in this country than there are people, and recognizing that the phenomenon of coöperation is an answer to certain definite personality needs, Mr. Barnard boldly attempts a pioneering job.

And does it well.

Eight chapters deal with the theory underlying organization and coöperative systems. There is assiduous effort to avoid particularization—which immensely increases the value of the book, but makes it most difficult reading. With each step the reader stops to "try it out" in industrial, religious, familial, and so forth, types of coöperative enterprise. This is laborious, but gives rich returns. Writing that so carefully protects itself from the assaults of exceptions is, on its face, lifeless, but here is a sound and meaningful analysis of why and under what conditions individuals coöperate in organized effort.

Eight more chapters claim to discuss the position and functions of

the executive in the light of the foregoing, but in reality extend far beyond this to cover many problems involved in the management of coöperative systems. Executed with the same care and precision as is Part I, this is a far more "readable" contribution. I suspect that this is because the reader is not constantly invited to "test the strength" of the statements in anywhere near so wide or so diverse a field. So often, in precisely this same way, we are inclined to consider a statement "practical" that does not open up too large a number of vistas!

There is a final chapter of recapitulation, which the hurried reader need not turn to as a means of rapidly "covering" the book. The sixteen conclusions are accurately drawn, but have little meaning for one who has not wrestled with the text. An earlier lecture [1] which touches many of these same problems, but discusses particularly the part of "intuitive" thinking in problems of management, is added as an appendix.

The temptation to dissect a book that contains a number of ideas completely new and startling to the psychiatric world is controlled by the closely written character of the material. It is difficult to lift out specific parts. To those in the general field of psychiatry who happen to be interested in what their clients are chiefly occupied in doing—namely, coöperating with others—the whole book can be recommended without qualification. Mr. Barnard has promised an elaboration, in the field of application, of his excellent exposition of the authority of formal organizations as deriving from the components of those organizations. This is an especially fine part of the book, as is also his picture of the major rôle of the executive as a communicating agent in organizational operation. These matters have much the same ring as the recent psychiatric formulations as to the extent to which those things that persons do with others are functions of internal drives and needs. It is most heartening to find this sort of support from the sociological approach. The author's acceptance of "morality" in the executive as existing in terms of his adherence to the values that he has set up is again arriving at a conclusion envisaged by the psychiatrist, who has come at the problem from a different angle.

Here is one of the few things that have been done in that No Man's Land between the individual and the social sciences. Is it, indeed, men like Barnard (dealing with the question how organizations can be built up) and Rowland (concerned with the question how organizations can be broken up) who are going to paint the picture of the

[1] *Mind in Everyday Affairs*, delivered at Princeton University in 1936 and given, I believe, rather wide distribution.

personality in culture? It is here that this book makes its greatest appeal; man is his cultural pattern, and organization can persist and be understood only in terms of its answering certain needs in the persons who coöperate in it.

Three statements that on their face are criticisms are really acknowledgments of the book's stimulation:

The psychiatrically minded reader will tend to feel that Part I is superficial because the values chiefly discussed are those "in relation to coöperating on the basis of moving a stone" (or those of a similarly mundane character). In testing these same values, but now considering those "in relation to coöperating in satisfying various identification tensions in the love life" (or those of a similar emotional connotation), I have found Part I equally sound. A somewhat longer exposition, making this point clear (with illustrations), would have much more surely commended the whole volume to the thoughtful consideration of those who trade so largely in the field of emotional problems.

Perhaps no one is more aware than Mr. Barnard himself of the immense importance of that area in human relationships which is not subject to verbalized or "logical" treatment. Possibly it is because of this that he is so casual in warning the reader of its existence. Thus when, near the end of the book, one reads that "in the common-sense, everyday, practical knowledge necessary to the practice of the arts, there is much that is not susceptible of verbal statement—it is a matter of know how," one can go back to find that the author at no point oversteps the limits of this statement. But in our day, when the psychoanalysts would verbalize the entire emotional life, when marriage counselors would build techniques for the entire sexual adjustment, and education would pin its faith entirely to curricula, this sort of statement needs to be blazoned at the top of each new page—and it would do no harm to place it on the cover!

Each discipline seeks integrity. Grotesquely enough, it finds it in a sister discipline. The psychologist finds it in the neurone; the physiologist finds it in the chemical compound. The sociologist is peculiarly vulnerable at this point because, in finding integrity in the person, he has but to look about him to find many a mirage of wholeness—of entity. Admiring immeasurably this piece of work, I yet wonder whether Mr. Barnard has not banked too much on the wholeness of people. They are, in turn, quite as much at the whim of physical and mental "sub-individuals" as are organizations at the mercy of smaller subgroups.

The obverse of this "criticism" Mr. Barnard is thoroughly aware of and brings it to the reader's attention. This is that as the parts

of an individual change their character or even lose their reality when abstracted from the total individual, so the "parts" of an organization become very different affairs when treated apart from that organization. This failure to measure the "meaning which an organization has as such," this distortion and destruction that are inevitable in analysis, can be suffered only as a necessary evil in the didactic process.

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A HANDBOOK OF ELEMENTARY PSYCHOBIOLOGY AND PSYCHIATRY. By Edward G. Billings, M.D. New York: The Macmillan Company, 1939. 271 p.

Dr. Billings presents here in clear and concise form a summary of the basic principles of psychobiology and psychiatry as advanced and taught by Adolf Meyer. The book is in five parts, which deal, respectively, with psychobiology, psychiatric-examination procedures, general psychopathology, general principles of psychotherapy, and selected reference material.

The book is a true handbook, in the Anglo-Saxon sense, rather than in the German sense. In spite of its diminutive size it offers a great amount of information that will be useful to students, and even more so to physicians who want a quick review of the various subjects preparatory to examination. For fuller exposition of the individual topics, larger works must be consulted.

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THE CONTRIBUTIONS OF CUMULATIVE PERSONNEL RECORDS TO A TEACHER-EDUCATION PROGRAM. By Rebecca Catherine Tansil. (Contributions to Education, No. 764.) New York: Teachers College, Columbia University, 1939. 158 p.

Dr. Tansil's book is an account of the ways in which cumulative personnel records have been used at the State Teachers College at Towson, Maryland, during a trial period of more than six years.

This report suggests many values that follow from the use of cumulative records. They make possible a developmental study of the student and provide the background material for guiding the recent graudate during the difficult years of adjustment to the new profession. Partly because the forms used presented so much information about the students, and probably also because the experiment with the new form aroused considerable interest among both students and teachers, Dr. Tansil found her colleagues referring to these records more frequently than they did to the usual college records.

A significant difference between the Towson College cumulative personnel records and the traditional student record card is the importance that is attached in the former to data relating to the student's personal and emotional adjustments. Term grades are included, as they should be, but they are not elevated to the false prominence they enjoy on most forms. Considerable use is made of such other sources of information as participation in extra-curricular activities, special skills and aptitudes, financial problems, and summer activities. The comments that are included on the record, as in the usual anecdotal behavior record, help one to see the student as an individual, with talents and weaknesses, with interests and difficulties. The detailed analysis of the student's experiences in supervised teaching, with its citations of the evidence of his fitness for teaching and suggestions for growth, should help both the student and those who are guiding him.

Dr. Tansil apparently agrees with Odenweller, whom she quotes, that the correlation between personality and success in teaching is greater than is the correlation between either college work or student teaching and teaching success. Her report becomes increasingly significant when it is viewed as one way of focusing attention on the personality development of prospective teachers. A program such as hers should foster the selection of future teachers with regard to their development as individuals as well as their attainments as students.

This report should be helpful to those who are in a position to modify the records at teacher-training institutions. For such readers, the book presents a detailed analysis of the ways in which the records were used and evaluated. At times the reader will regret that the book appears as a doctoral dissertation, for it is essentially the report of a practical solution to a realistic problem. Appearing in the format of a research report, there is a tendency to employ statistical procedures with data that do not warrant elaborate treatment, and to include substantiating data even where the conclusions are obvious or the question trivial.

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THE EFFECT OF VARIED AMOUNTS OF PHONETIC TRAINING ON PRIMARY READING. By Donald C. Agnew. (Duke University Research Studies in Education, No. 5.) Durham, North Carolina: Duke University Press, 1939. 50 p.

It is notorious that the English language presents many phonetic difficulties. Not only does it contain a large number of non-phonetic words, but certain letters and letter combinations have a large number

of possible sounds. The best method of meeting these difficulties in the teaching of reading at the primary level has always been a matter of controversy. On the one hand, some teachers have favored large amounts of phonetic training, on the ground that it is an aid in recognizing words previously learned, in reading new words, and in improving pronunciation and spelling. On the other hand, it has been urged that phonetic training tends to isolate words from their meaning, to sacrifice interest in reading, and to hinder rapid silent reading.

Agnew tested matched groups of third-grade children in the schools of Raleigh, North Carolina, one group having received very little and the other a moderate amount of phonetic training. He obtained negative or inconsistent results. However, children in the Durham schools who had received large amounts of phonetic training proved reliably superior on twelve of fifteen tests over the children in the Raleigh schools who had received little or moderate amounts of phonetic training.

These findings require further confirmation, since, in spite of careful selection and equating, it is possible that some factor other than phonetic training was responsible for the superiority of the Durham children. Save for this doubtful method of comparing children in different school systems, the study is competently executed. Special students will be interested in a number of minor procedural innovations which are generally applicable to problems of educational research.

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AMERICAN PSYCHOLOGY BEFORE WILLIAM JAMES. By Jay Wharton Fay. (Rutgers University Studies in Psychology No. 1.) New Brunswick, New Jersey: Rutgers University Press, 1939. 240 p.

The psychology of to-day is essentially a branch of biology "with strong leanings toward physiology and neurology." The contrast between this newer approach and the philosophical psychology that it has displaced is made clearer by the present chapters. They sketch the history of the two-century period before William James which scholars usually dismiss with a line or so of condescension.

As in Europe, these early attempts at a science of the human mind were the business of speculative philosophers. When, in 1640, Henry Dunster became president of Harvard and set up courses in philosophy, ethics, and divinity, psychology did not even have a name. It was a branch of moral philosophy, when philosophy itself was unthinkable apart from theology. A rationalistic turn was

given by the coming to America in 1714 of a copy of Locke's *Essay Concerning Human Understanding.*

The second period, which Mr. Fay calls that of intellectual philosophy, extends roughly from the days of our Revolution to our Civil War. The authors studied were the Scotch philosophers, Reid and Stewart, until in 1827 Professor Thomas C. Upham, of Bowdoin College, published the first comprehensive, well-organized American textbook, *Elements of Intellectual Philosophy.* The third period (1861–90) brings us down to 1890, when William James devoted a chapter in his *Principles of Psychology* to the reasons why it was no longer possible to believe in "the soul." This was the period when German interest in psychophysics and physiological psychology (the days of Weber, Fechner, Wundt) was maturing, when England was accepting the evolutionary theories of Darwin and Spencer, and when Galton was beginning the study of individual differences. This period of British and German influences did much—though there was not always complete awareness of the fact—to separate psychology from philosophy as a science of its own.

The author appreciates that there are places in America where psychology is still taught—in whole or in part—as it was before 1890—that is, as if "the soul" were there to be studied. The reasons are not always discreditable. Just where, for instance, shall we draw the line between physiology and psychology, or just how far can an empirical science in this one highly complex matter dispense with the philosophic insights of students interested in human beings in their entirety? The answers to these questions are not at all unanimous. In some places, moreover, "scientific psychology" is a highly narrowed, academic discipline which adds nothing important to our knowledge of human beings.

But at any rate, all who wish to enrich their understanding of people will be in a better position to get their psychologic bearings from reading this able study of the tradition out of which America was to be led by James, Hall, and Dewey. That later ages discarded the findings and the methods of earlier scholars must not blind us to the fact that these earlier approaches prepared the ground out of which the new knowledge sprang. Mr. Fay deserves thanks for this well-documented study of the old-timers.

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NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The war in Europe and its implications for America inevitably colored the deliberations of the American Psychiatric Association at its Ninety-sixth Annual Meeting, held in Cincinnati, May 20–24. Dr. William C. Sandy, retiring president of the association, in his presidential address, reported on plans to meet a possible national emergency requiring the services of trained psychiatrists. He said that the association was compiling personnel data through a "military questionnaire, used only in the United States, which has for its objective preparedness for meeting the requirements of any national emergency." A special round table on "Psychiatry and Military Mobilization" was held for the purpose of discussing various psychiatric phases of the medical mobilization plans now receiving attention in the offices of the Surgeon-General of the United States Army and Navy, as a part of the program of national defense.

Some of the new problems and difficulties that have to be faced in preparing for the eventualities of modern warfare were brought out in a paper by Capt. Dallas G. Sutton, psychiatric member of the Medical Corps, U.S.N., who pointed out the high degree of mental efficiency and integration now required of men in the naval services. He said that the necessity for recruiting only "the best integrated individuals who could stand the gaff psychologically as well as physically" has led to an increased appreciation of psychiatric and psychological factors in the selection and training of men for the navy. He reported that the navy was also now engaged in research problems, many of which had a psychiatric aspect, such as studies in the field of aviation involving mental reactions to altitude flights, fatigue oxygen supply, and so forth; in submarine work, on psychosomatic reactions at varying depths; and finally in connection with the larger ships of the fleet, where investigations are being made into the effects of heat, relative humidity, and so forth. He concluded that every reasonable step must be taken to prevent the entrance into the service of individuals predisposed to mental and nervous disorders. This may be accomplished, he added, at training stations, by careful planning and the utilization of the best available psychiatric talent.

The scientific papers presented at the various sections meetings dealt with numerous phases of the mental-disease problem, new findings being reported on epilepsy, schizophrenia, drug addiction, mental deficiency, involutional melancholia, and the manic-depressive psychoses. Pharmacological shock therapy received special attention, as in previous meetings of the association, and a variety of therapeutic, clinical, and laboratory studies were described.

Drs. V. P. Sydenstricker and H. M. Cleckley, of the University of Georgia, reported that nicotinic acid, the remarkably effective curative agent for pellagra, is now being used to clear up mental conditions characterized by stupor, lethargy, and depression, even when there are no physical signs of pellagra. "Usually," they said, "the response to nicotinic acid was prompt; often it was spectacular." Their experiments led to their belief that many patients whose mental condition suggests the diagnosis of some form of psychosis or exhaustion delirium may be relieved of their symptoms by the administration of this drug.

Dr. Harold D. Palmer, of Philadelphia, suggested that involutional melancholia, commonly ascribed to "change of life," is only infrequently directly due to this cause. His conclusion was based on studies of 53 cases of this form of melancholia, in which he found that in only 13 was the menopause a factor in the development of the mental illness. More important, he said, was the personality pattern of the individual; and recoveries from the illness, too, seemed to be based in some measure on the previous personality development of the patient. All those who failed to recover showed marked restriction of the mental horizon during life and a majority showed "obsessional" character.

A new test for determining the "conceptual quotient," based on the loss of ability to think in terms of categories, was described by Dr. Walter G. Shipley and Dr. C. Charles Burlingame, of Hartford. By means of this test, it was explained, early mental deterioration could be discovered, making it possible frequently to detect incipient mental disease. The theory of this test is based on the fact that mental impairment usually begins on the high level of abstract thinking or the ability to think in terms of concepts. At the same time, vocabulary is usually the least affected, the habitual usage of words remaining after other faculties are seriously diseased. The conceptual quotient is obtained by testing the subject on vocabulary, and then on other tests which measure abstract thinking ability, the disparity between the two results indicating the conceptual quotient. The scale was standardized on over a thousand normal subjects for whom I.Q.'s were available, mental age equivalents being established for the vocabulary and abstract-thinking tests as well as for the two

tests combined. Subsequently, "C.Q." tests were also given to several hundred mental patients, thus confirming the original tenet that the tests were useful in measuring intellectual impairment.

The theory that structural damage to the most recently evolved portion of the brain may explain the behavior of chronically antisocial individuals was offered by Dr. John Chornyak, of Pittsburgh, who urged psychiatrists to give more attention to this large group of criminals and to attempt scientific measures for their study and segregation. "Egocentric, emotionally unstable, psychopathic personalities with self-thwarting behavior," he said, "belong to a group that has long been recognized as exhibiting antisocial reactions or criminal behavior from earliest childhood. They form our most serious type of delinquent and criminal, and the tremendous harm done to society by them should force psychiatry not only to recognize their numerical and social significance, but also to establish diagnostic criteria for their segregation. It is our contention that this type of psychopathic personality is fixated at this early egocentric level because of damage to the most recently acquired area in the cerebrum. One of the effects of this damage in the angular and supramarginal gyri is reflected in abnormalities of the body schema."

The following officers were elected for 1940–1941; *President,* Dr. George H. Stevenson, of London, Ontario; *President-Elect,* Dr. H. Douglas Singer, of Chicago; and *Secretary-Treasurer,* Dr. Arthur H. Ruggles, of Providence, Rhode Island. Richmond, Virginia, was chosen as the place for the next annual meeting of the association.

Program of the American Law Institute for Dealing with Youthful Offenders *

The American Law Institute is a representative body of highly qualified lawyers who have engaged in much research and many deliberations concerning various phases of the law. This has led to the well-known Restatements of the Law, which have had great influence in bringing about legislative modifications of legal procedures.

For over two years a committee appointed by the institute and granted liberal funds by the great foundations has been engaged in considering the problems presented by youthful criminality. The task of this committee has been the framing of a social enactment for the handling of youthful offenders prior to trial, during trial, and afterward. The term "youthful offenders" means those between

* Abstract of a paper on "Psychiatry and the Treatment of Youthful Offenders in the Plans of the Committee of the American Law Institute" presented by Dr. William Healy at the Seventeenth Annual Meeting of the American Orthopsychiatric Association in Boston. Printed by permission of the association.

the ages of sixteen and twenty-one years or between the upper limits of the juvenile-court age and twenty-one.

This age group is taken because during this period there is a tremendous increase in criminality, so that at nineteen or twenty years the highest peak for serious crimes against property is reached, especially crimes of this type accompanied by violence. This is the age at which criminal careers may be said to be definitely entered upon. The figures for arrests and sentences during these five years are very high throughout this country, and our lack of success in dealing with young criminals is attested by the high percentage of repetition of offense after treatment under the law.

Yet it would seem that this should be the most promising time of life for dealing with such offenders. Either through reforming larger numbers, or through segregating for much longer periods those individuals who, for one reason or another, give promise of becoming habitual criminals, different methods from those now utilized are imperative. The object of the proposed enactment is to initiate more effective methods of training and treatment, and thus better to safeguard society.

A great stimulus to the work of the committee was given through the publication of *Youth in the Toils*—a study of youthful offenders in New York City, by Harrison and Grant. The proposals for improved methods of dealing with young criminals made in that book by Leonard Harrison have received much attention by the committee.

The nineteenth draft of a model enactment was printed and sent to many authorities for criticism. A later draft is now before the Law Institute's Council for consideration. It is the combined work of a group in which not only the law was represented, but also sociology, criminology, and psychiatry.

At first spoken of as a "Treatment Tribunal," in the last draft the enactment is entitled "A Youth Correction Authority Act." This model enactment provides that all persons of the youth group convicted of a criminal offense shall be turned over to the correction authority, which shall determine matters of probation, institutional segregation and treatment, and parole. With certain definite provisions for frequently reviewing the case, the authority can, if it is deemed necessary, hold an individual under its charge and treatment for a prolonged period. Indeed, if he remains dangerous to society, control may be continued until the individual is twenty-five years of age. Even then, under an appropriate court order, there may be a further continuance.

The act provides for an early careful study of the cases of all offenders, whether after commitment they are allowed at liberty

under conditions of probation or are assigned to some particular type of training or of segregation.

The types of correctional training and treatment are to be widely diversified, being suited to the needs of the individual. The central idea in this part of the program is to do away with the mass methods of treatment now in vogue, which have proved exceedingly ineffective.

It is recommended that the authority consist of at least three members who shall establish and administer the training and treatment service and pass judgment upon all important matters. Above everything, their duties are related to the idea of doing away with retributive punishment, particularly as this is exemplified by giving specific sentences for specific offenses. As every one knows, such sentences are not prescribed with a main view to what can be done to reform the offender and do not meet the needs of society in the matter of its own protection.

There may be comparatively few requirements for the establishment of new and expensive institutions, but carrying out the common-sense provisions of this enactment will call for a specially qualified personnel who will not only diagnose the needs of the individual from many standpoints and allocate him to special groups, but who will also carry out the training and treatment program—that is, if he is regarded as an institutional case. It is clear that, on the one hand, many reclaimable individuals will be dealt with either on probation—perhaps even then with certain provisions for training—or in more open types of institutions. And on the other hand the comparatively short terms that now are very frequently given to desperate or abnormal types of individuals will be replaced by long segregation, and it is to be hoped also by experimental methods of corrective training and treatment.

If the American Law Institute passes favorably upon the recommendations of its committee, undoubtedly a period of public education will be necessary to bring about the enactment of this scientifically oriented plan for the control of youthful criminality.

Progress in Dementia-Praecox Research

Dementia praecox, most prevalent of all the hospitalized mental disorders, is receiving the serious attention of a group of scientists in the most significant effort yet undertaken to probe the causes of this obscure disease. Some 74 investigators in 13 scientific centers are engaged in what is the first organized, coördinated long-range attempt to get at the fundamentals of the problem.

Workers in various branches of medical science have pooled their resources and techniques in an integrated series of researches dealing

with special aspects of the disorder, from the standpoints of psychiatry, neurology, psychology, physiology, chemistry, genetics, and other biological disciplines, welded together in a comprehensive and unified attack on this many-sided problem. For five years now they have been at work on some 20 specific projects. Last December, some 40 of these investigators came together, in an all-day conference in New York City, to evaluate progress, exchange views and experiences, discuss methods and objectives, and further to facilitate coördinated development of their studies.

Interestingly enough, the impetus for the enterprise came from a group of laymen, the Supreme Council, 33°, of the Northern Masonic Jurisdiction, Scottish Rite, U. S. A., who, after an extended canvass of the broad field of philanthropy, decided, in 1934, to devote a substantial part of their benefactions to the support of research in this most difficult sector of mental medicine.

The first year was spent in a preliminary survey of the status of scientific work on dementia praecox in this and other countries, conducted by Dr. Nolan D. C. Lewis, of the New York State Psychiatric Institute and Hospital, under the direction of a special advisory committee appointed by The National Committee for Mental Hygiene and composed of outstanding leaders in psychiatry and allied medical sciences. This committee mapped out a plan of attack and selected, out of scores of problems, those disclosed by the survey as presenting promising openings for an initial series of investigations. Up to $50,000 has been allocated from the Scottish Rite fund each year among the several hospitals, clinics, laboratories, and university departments engaged in the studies in widely separately cities.

Dementia praecox, characterized by Dr. Lewis, field representative of the National Committee and coördinator of the research program, as "the largest unsolved medical problem confronting science to-day," afflicts more people than any other disabling disease in the whole category of mental and physical ailments. Approximately half of all hospital beds in the United States are occupied by mental patients, and of these about 50 per cent are diagnosed dementia praecox. The economic loss from the disease runs to nearly a million dollars a day, considering the investment in treatment facilities and the loss of earnings, while its costs in human misery can hardly be calculated. To a large extent it is a mental disease of youth, and since so many of its victims enter mental hospitals early in life and remain for years, there has been a steady accumulation of dementia-praecox patients, resulting in a constantly increasing medical, economic, and social burden which has been only slightly relieved by the newer forms of insulin and metrazol shock treatment.

The disorder, known technically as schizophrenia, is frequently

found in individuals with highly organized minds, who early in life give promise of brilliant careers. The earliest manifestations of trouble are often difficult to determine, subtle in their expressions, and slow in development. In the typical case, the creative potentialities of the mind gradually become involved in a daydreaming, emotionally distorted process which cripples the personality and gradually leads to a type of deterioration of character that shows itself either by a tendency to withdraw from social activities, or by an aggressive attitude, overstepping the bounds of societal tolerance. This premature deterioration of character is not explainable on the basis of any of the known physical diseases, and it is this fact that emphasizes the unusual difficulties presented in research on the disorder and the necessity of unusual methods of investigation.

It is too early, Dr. Lewis reports, to appraise progress in very definite and conclusive terms at this point in the investigations. A considerable number of positive and negative findings can be selected from the studies now under way, but they are tentative discoveries and must be tested further. They are moving forward, however, to a point where practical results are beginning to be observed in the disclosure of hitherto unknown factors in the disease. Indeed, it is felt that the newer approaches to this problem are quite as promising and hopeful as those so fruitfully developed in the research in cancer and other diseases.

The whole life span is encompassed in the plan of these studies, which cover such facets of the problem as are more directly open to observation and experimentation, each research project being related to every other as part of a coördinate whole. In order to utilize as many approaches to the problem as are feasible, and to obtain a diversity of ideas, the advisory committee decided that not only workers in psychiatry and psychology should be consulted, but also scientists in other fields of research, particularly those engaged in the so-called biological sciences—that is, investigators studying the vital structures and activities of living beings and tissues. The attempt is, therefore, to learn of the various possibilities in the realms of ethnology, heredity, infant growth and behavior, physiology, pathology, and chemistry, as well as in experimental psychology and psychiatry itself.

To begin with, there is the difficult problem of differential diagnosis. Dementia praecox is an exceedingly complex and heterogeneous disorder, and in two of the studies an attempt is being made, by statistical and clinical methods, to develop greater precision in the observation of significant symptoms and factors in the disease, with an eye to greater accuracy of diagnosis, and with a view to determining the value of various treatment procedures and devising a means of prognosticating the probable outcome in certain types of case. A

promising diagnostic aid in this connection is the electro-encephalograph, which registers the electrical changes that accompany brain activity. The purpose of one of the studies in progress is to determine whether sufferers from dementia praecox show brain-wave patterns that are characteristic for the disease and different from those in patients suffering from other types of mental disorder.

Fundamental questions relating to dementia praecox and to human behavior in general will not be answered until certain basic knowledge is secured concerning the functioning of the elements (neurons and connectives) out of which the nervous system is composed. One series of experiments is contributing to an understanding of the properties and activities of single nerve cells—how these properties are altered by changes in their chemical environment, how one nerve cell acts on another and thus integrates the unit of nervous action into an organized pattern of behavior. In another experiment investigators are studying the transmission of nerve impulses in the spinal cord of monkeys, cats, and dogs, the action of insulin on the electrical activity of nerves, and the spread of nerve impulses through the central nervous system.

Insulin and other experimental drug therapies are the points of departure for studies that aim at a better understanding of the physiologic basis of shock treatments, to determine the types of schizophrenic patient most likely to benefit from such treatments, and to find new clues as to their mode of working. Means have been discovered to guard against physical injury resulting from the convulsions induced by metrazol medication, and research is being carried on toward the preparation of a synthetic substitute that may give the good and eliminate the bad results of such treatment.

In studies of the constitution and body structure of patients afflicted with dementia praecox, attention has been centered on investigations of the circulatory system in which a new technique is being employed, involving the use of a sort of modified ophthalmoscope, through which the functioning of body organs can be observed microscopically in the living human being. In the womb of the mother, the retina is a part of the brain and continues as brain tissue throughout life. With this apparatus the functioning retina of a living eye can be actually seen and its vascular system measured. Although these experiments are in an early stage, there are indications that cases of dementia praecox that will and those that will not improve with insulin or metrazol treatment can be selected with considerable accuracy on the basis of the capacity of the vascular bed (retina).

The study of dementia praecox in its earliest manifestations are particularly important as it is here that the influences of physical disease, disorders of nutrition, glandular trouble, family and environmental maladjustments can be studied and frequently corrected in

time to have a beneficial effect. In one of the studies in progress, an attempt is being made to obtain a clearer understanding of schizophrenic development in the individual in the immediate period before frank mental illness appears, in the hope that earlier recognition of the condition will help in averting a breakdown.

In another project, a group of 8,000 school children are being studied with reference to the relation of extreme shyness and timidity to dementia-praecox symptoms. This investigation is significant from the standpoint of therapy and prevention, since a large proportion (estimated from 40 to 60 per cent) of adult patients suffering from dementia praecox have shown in childhood a noticeably shy, timid, recessive type of personality. Of the 8,000 children studied, 6.5 per cent were found to be shy and recessive, and of a group of 51 of these recessive cases, 31 developed a considerable degree of poise, self-confidence, and success in social relationships, through improved educational procedures.

A further study of early manifestations of the disorder carries the search for pathological indications back to infancy and the prenatal period, in an effort to determine what significance certain behavior reactions in new-born babies may have for mental health and personality development in later life. Sucking behavior was studied in 600 babies to see how they made this first adjustment to life, and to determine whether tendencies exist from the beginning to react negatively or in a disorganized way to maternal care. Ten per cent in this group showed marked feeding difficulties, ranging from refusal to nurse at all, though restlessness and excitement, to the opposite reaction of becoming passive and lethargic. The investigator, a specialist in obstetrics and psychiatry, is making detailed observations of this initial manifestation of coördinated "psychic" behavior in infant nursing reactions, considered as prototypes and possible indicators of future mental and emotional disturbance.

The question of heredity in dementia praecox is being investigated by a geneticist through a series of researches on schizophrenic and tuberculous twins, which seek to establish the specificity of predisposition to schizophrenia, the pattern of its hereditary transmission, and other factors in the complex manifestations of predisposition. There is evidence pointing to a close genetic relationship between the tendency to schizophrenia and hereditary low resistance to tuberculosis, as shown by statistical and clinical studies of several hundred pairs of twins in mental hospitals and tuberculosis sanitaria.

More remote, but significant in their bearings on knowledge concerning cultural influences on mental health, are the studies conducted by an anthropologist among the aboriginal tribes of Bali, in connection with trance phenomena, child training, symbolic play, speech forms, and social sanctions. The records of these observations,

which have been brought back to America and will be analyzed during the next twelve months, may indicate factors in Balinese culture that seem significant in developing personality types that have schizoid (dementia praecox) characteristics.

Thus are the searchlights of science trained on this extremely serious problem of dementia praecox, in the hope that persistent, patient, and painstaking original inquiry may in time penetrate the dense fog that hides the essential causes of this disease and shuts out from the world of normal life many thousands of unfortunate sufferers who are still, for the most part, beyond reach. The situation is becoming more and more critical, said Dr. Lewis, as year by year this huge medical, social, and economic octopus of mental disorder increases its burdens on the people, not only financially, but in its heartrending disruption of family life. Hence the timeliness and importance of this effort. The example set by the Scottish Rite Masons in initiating and financing these investigations into dementia praecox has brought the problem into the foreground in the minds of a great number of scientific thinkers, many of whom have reacted to the stimulus of this undertaking by starting important work on particular phases of the problem.

Financial aid from the Federal Government and a number of other sources, Dr. Lewis points out, is available for the study of five diseases selected as targets in the fight for the nation's health—namely, cancer, syphilis, infantile paralysis, malaria, and yellow fever. Dementia praecox, of which, like cancer, there are several varieties, is not included in the average health program, yet it destroys more people and careers than all the others added together.

"The fact that we are dealing with a very complex problem," Dr. Lewis concludes, "should serve as an additional stimulus and challenge to the best minds in the country, and should lead to increased public and private support of investigative work in this field. Most of the limited support now available for psychiatric research comes from private sources, such as the benevolent funds and foundations, and it is hoped that the Federal and state governments will do more in this field."

Texas Creative Community *

In the great stream of life there is an undertow into which fine personalities are drawn unawares. Intelligent, idealistic young men and women, who are grasping for vital purposefulness of life and opportunities for creative living, are overwhelmed with frustration as

* Abstract of a memorandum by Mathilde C. Maier, of the Texas Creative Community Association.

they seek for enduring values in the institutions of home, college, vocational fields, and church. Many break down and enter mental hospitals. Here they regain their physical health, find freedom from emotional stress, and have their zest for life revived. With renewed strength and revitalized hopes, they return to society, only to be confronted again with frustrating environmental difficulties and recurring symptoms which are beyond their control. Many of them have no opportunities for developing their assets, because of inadequate vocational preparation, financial stress, and unfavorable attitudes of relatives and former employers. In reaction to adverse circumstances, they become economic liabilities, and society has to bear the burden of lost man power, with an increase in taxes to sustain human misery. Instead of progressively increasing appropriations for institutional care of the mentally disabled, provisions should be made for adequate training in better adjustments, by means of vocational and cultural education, creative work, and constructive recreation.

This is the thesis back of a plan conceived by an organization recently formed in Texas for the establishment of a creative community for the purpose of increasing the efficiency and happiness of intelligent, desirable young persons and thus reducing suffering and providing a check on increasing tax burdens. The plan had its origin in a recommendation made by the Texas State Board of Control in 1936, for the setting up by the legislature, in conjunction with the Galveston State Psychopathic Hospital, of a supervised "transition" community to aid in the readjustment of former patients. In 1939, Dr. L. R. Brown, superintendent of the Galveston institution, requested an appropriation for such a project, but the time was not opportune for favorable legislative action.

The Social Welfare Association had considered the problem of such patients. Recently, however, a group of Texas citizens have been studying the needs for rehabilitation and extending opportunities for readjustment for those who require assistance, in accordance with psychiatrists' recommendations. These citizens have incorporated The Texas Creative Community, Inc., a non-profit organization for the purpose of meeting readjustment needs, and they are now promoting interest in the establishment of this community. An executive committee and board will outline the policies and plans for securing funds.

The satisfaction of achievement in purposeful work, of becoming familiar with actual living conditions, of gaining the respect of fellow workers, and other factors contributing to a feeling of competence and security, are the objectives and guiding principles of the proposed community, which will provide a variety of activities, for which the members will be suitably compensated. Efforts will be made to have the community affiliated with business establishments

and professional institutions so that the members may be assigned to voluntary or remunerative work which meets the individual's needs. Coördinated with the project will be educational facilities for vocational and cultural purposes, such as extension and correspondence courses, and a certain amount of time will be devoted to social activities which are essential in the development of the total personality.

Requests for admission to the community will be passed upon by the executive board, in coöperation with a psychiatrist. Men and women who have the ability to coöperate and adequate personal qualifications, who are in need of opportunities for training in adjustment or vocational education, will be eligible. They will be expected to develop desirable habits of industry and social coöperation, and to participate enthusiastically in a program of study, work, and recreation. Whenever members have opportunities to secure regular work outside of the community, they will be encouraged to accept it. The duration of residence in the community will not be limited, provided the members make definite contributions for the benefit of themselves and their associates.

The community will be located in a desirable rural district in proximity to educational and industrial centers. It is estimated that approximately $10,000 will be required for the initial set-up, or $50,000 if the land is purchased instead of leased. This amount will be raised by private subscriptions and possibly by grants from foundations and funds, and in the course of time appeals may be made for state and Federal aid. It has been suggested that the use of one Federal Resettlement Community might be secured temporarily or permanently. Whenever possible, the members of the creative community will be requested to pay for room and board; however, persons who cannot afford to pay will have the privileges of participating in all the activities. As the work of the community progresses and becomes profitable, the members will receive remuneration for special types of work. Ultimately the community may become partially or totally self-supporting.

Directory of Psychiatric Clinics in the United States, 1940

The National Committee for Mental Hygiene announces the publication, in reprint form, of its revised (sixth edition) Directory of Psychiatric Clinics in the United States, which shows the mental-health services available for children and for adults. The new canvass on which the directory is based reveals over 700 public clinics in operation in 440 cities, towns, and villages, in 34 states. The directory defines a clinic as one that has a psychiatrist in attendance at regu-

larly scheduled hours; and the services offered as "those available generally to persons in the lower income brackets who would under usual conditions be eligible for free or low-cost medical care at a dispensary." The list includes not only the title and location of each clinic, but information as to hours of appointment, personnel in attendance, and auspices under which the clinic is held. Teachers, nurses, doctors, ministers, social workers, and others will find it of practical value in directing parents who are troubled by behavior disorders in their children, or adults who are concerned about their own mental health, to sources of competent professional advice and help. The directory can be secured from The National Committee for Mental Hygiene, 50 West 50th Street, New York City, at fifty cents per copy. Orders should be accompanied by remittance.

Mental Hygiene at the World's Fair

Education for mental as well as for physical health again receives appropriate emphasis in the medical and health exhibits set up at the New York World's Fair during the 1940 season. A new and improved edition of the Mental Hygiene Exhibit sponsored by The National Committee for Mental Hygiene last year has been organized by the American Museum of Health, which is in charge of the Medical and Health Building and which will retain the various displays for its permanent exhibit after the Fair.

As before, the mental-health exhibit undertakes to convey in simple, but dynamic fashion some of the fundamental teachings of mental hygiene, stressing the personal application of mental-health principles and practices.

The main features of the exhibit, which consists chiefly of mechanical devices, include a "question box," which flashes some of the questions most commonly asked in the field of mental health, together with authoritative answers; a "mental-balance machine," which illustrates the balancing of the forces of personality in dealing with various life situations; and a distortion mirror, which symbolizes the concept of insight into one's mental and emotional make-up, one's assets and liabilities, and other personality factors, summed up in the familiar precept, "Know Thyself." A mural painting, which shows successful types of adjustment contrasted with figures depicting maladjustment in its various forms, and the institutions, clinics, and other agencies available for remedial purposes, provides a colorful background for the three-dimensional display.

To judge from the experience of last season, this experiment in mass health education promises again to be successful. The medical

and health exhibits were among the most popular at the 1939 Fair, attracting some 7,500,000 visitors out of a total attendance of 26,000,000.

Austen Riggs Foundation

At the annual meeting of the Austen Riggs Foundation, Inc., held in Stockbridge, Massachusetts, on May 11, 1940, Horace K. Richardson, M.D., F.A.C.P., was elected medical director of the Foundation, succeeding Austen Fox Riggs, M.D., who died on March 5, 1940. Robert B. Hiden, M.D., was elected senior assistant medical director, and Charles H. Kimberly, M.D., junior assistant medical director.

Social Work Vocational Bureau Establishes Service

The Social Work Vocational Bureau has opened its office at 122 East 22nd Street, New York City, to provide a national placement and counseling service in the social-work field. At present it offers service only in the case-work fields, including family and child welfare and medical and psychiatric social work. It covers positions for executives, consultants, supervisors, case-workers, and others for which an agency may require social-case-work equipment. It is planned later to extend the service to group work and other social-work fields as financing permits. Organized on a national basis, it will facilitate the distribution of available personnel through the clearance of vocational and job information between persons whose equipment is in demand and agencies that need social-work personnel.

The Social Work Vocational Bureau is organized on a membership basis for both individual social workers and local agencies, with annual dues and service on an annual basis. There is no placement fee for its services. Charter membership to individual members is offered to October 1, 1940, at $5.00 for the first year, with $4.00 annually for continuing membership. After October 1, the regular annual membership dues will be at the rate of $7.00, with $4.00 for continuing membership. Membership is provided for students at the rate of $3.00 for the first year. The annual dues for agency membership are on the basis of the number of professional staff positions for which the agency specifies social-case-work equipment. The minimum is $10.00 for agencies with three or less professional staff positions. For agencies with four or more professional staff positions, the dues are at the rate of $3.00 per professional staff position.

Further information as to the service program of the bureau, membership requirements, and dues, may be secured from the executive director, Louise C. Odencrantz.

The bureau is now receiving requests from agencies for personnel and inquiries from social workers interested in hearing about suitable openings.

National Conference of Social Work

Mental hygiene had a leading place in several of the programs and sessions at the National Conference of Social Work, which held its Sixty-seventh Annual Meeting in Grand Rapids, Michigan, from May 26 to June 1. The more prominent organizations represented in this field were the American Association on Mental Deficiency, the American Association of Psychiatric Social Workers, the American Association of Visiting Teachers, the National Association of Training Schools, The National Committee for Mental Hygiene, and the National Probation Association.

The problem of caring for mental defectives in the absence of institutional facilities received special attention at a meeting conducted by Dr. Robert H. Haskell of the Wayne County (Michigan) Training School. Professional education was a leading topic of discussion at the psychiatric-social-work sessions. At a joint session of training-school executives and the mental-hygiene group, the emotional development of the child during puberty and early adolescence was discussed by Dr. Henry C. Schumacher, of the Cleveland Child Guidance Clinic, Dr. Maud E. Watson, of the Detroit Children's Center, Dr. George S. Stevenson, of The National Committee for Mental Hygiene, and others.

At a joint session of The National Committee for Mental Hygiene and the American Association of Visiting Teachers, Harry A. Wann, Superintendent of Schools, Morristown, New Jersey, Miss M. Ethel Batschelet, of the Hartford, Connecticut, Board of Education, and other school leaders discussed the rôle of the visiting teacher in school and community relationships. And at a special meeting arranged by the National Committee, devoted to the problem of personnel, Dr. Temple Burling, of New York, Dr. Theophile Raphael, of the University of Michigan, Miss Helen Witmer, of the Smith College School of Social Work, and other psychiatric workers considered the question of selection of personnel for other elements than technical proficiency—namely, those personal aspects that are of importance to the teacher, the social worker, and others engaged in mental-hygiene activity.

Sex offenders, broken families, and educational measures for crime prevention were discussed by psychiatric and other specialists at the sessions on probation. The speakers included Judge Charles W. Hoffman, founder of the Court of Domestic Relations at Cincinnati; Alfred A. Gross, of the Payne Whitney Psychiatric Clinic, New York; Austin H. MacCormick, of the Osborne Association, New York; Judge Gustav L. Schramm, of the Juvenile Court, Pittsburgh; William Draper Lewis, of the American Law Institute; and Charles L. Chute, of the National Probation Association, New York.

Bucknell University Honors Dr. Stevenson

Bucknell University conferred the honorary degree of Doctor of Science on Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, at Lewisburg, Pennsylvania, on June 10. Dr. Stevenson received his B.S. from Bucknell in 1915, and his M.S. from the same institution in 1919. We quote from President Marts' citation accompanying the bestowal of this honor in recognition of Dr. Stevenson's distinguished attainments in the field of psychiatry and mental hygiene:

> Your Alma Mater is proud of your achievements in a science too long neglected. You are pioneering in an area in which each step forward will bring comfort and understanding to untold numbers of human souls.

Dr. Stevenson came to his present position of leadership in the mental-hygiene movement after a varied and unusual experience in mental hospitals and clinics, in teaching and research, and in other posts of responsibility in the wide field of mental-health work, which he occupied with distinction. For many years he was the outstanding spokesman for the child-guidance-clinic program which achieved nation-wide development under the ægis of The National Committee for Mental Hygiene. Before coming to the National Committee in 1926, he served in such leading medical and scientific centers as the Henry Phipps Psychiatric Clinic at Johns Hopkins University, the New York State Psychiatric Institute, the Cornell Medical School, the Vineland Training School, the University of Minnesota, and the Minneapolis General Hospital. He was appointed Medical Director of the National Committee in 1939, and is associated with numerous professional societies and scientific organizations in psychiatry, education, social work, and other fields related to mental hygiene.

Associate Child Guidance Clinics of New England

A new integration of child-guidance workers occurred on April 27, when staff members of several of the New England clinics met in Worcester. After an informal discussion of various aspects of clinic work, such as problems of intake and community interrelationships, it was decided that more such meetings would be very helpful in view of the many mutual interests of community clinics. The group then organized the "Associated Child Guidance Clinics of New England."

Three or four meetings of one day each are planned during the coming year, to be held in various clinics, for the purpose of "providing avenues for discussion of the policies and problems of child-guidance clinics, including treatment, administration, training of

personnel, community education, and interagency relationships." Invitations were extended to other clinics in the region with similar structures and interests.

There are now thirty-five members, including representatives of the Child Guidance Clinic of Springfield, the Worcester Child Guidance Clinic, the Providence Child Guidance Clinic, the Hartley-Salmon Clinic in Hartford, the Judge Baker Guidance Center in Boston, and the Habit Clinic for Child Guidance in Boston. The officers elected were Dr. H. B. Moyle, Hartford, President; Miss Clarace A. Galt, Springfield, Vice-President; Miss Roberta Andrews, Providence, Treasurer; Dr. Robert P. Kemble, Worcester, Secretary. Dr. Elmer Hageman, Hartford, and Mrs. Esther C. Whitman, Worcester, were made directors.

New England Conference on To-Morrow's Children

The Harvard Summer School and the National Conference on Family Relations announce "A New England Conference on To-morrow's Children," to be held at Littauer Center, Harvard University, Cambridge, Massachusetts, on July 24–26, 1940. The objectives of the National Conference of Family Relations are "to advance the cultural values that are now principally secured through family relations, for the advantage of the individual and the strength of the nation." In support of this program, the projected conference will aim to bring together New England and national leaders, teachers, research workers, and others in many fields, for an exchange of views "as to ways and means of improving both the hereditary and environmental endowment of to-morrow's children in New England," and to provide an opportunity for all interested persons to meet in small round-table discussions "to consider problems and possibilities of regional planning and action toward family building and population development."

The preliminary plans call for three afternoon planned panel discussions on (1) the underdeveloped family, (2) the overdeveloped family, and (3) the balanced family, with subsidiary round-table discussions. The opening morning session and three evening sessions, with lectures and conference summary, will be open to the general public without charge. A registration fee of $2.00 will be charged to all except Harvard Summer School students for participation in all the sessions. Inquiries regarding living accommodations and other details should be addressed to New England Conference on To-morrow's Children, c/o Harvard Summer School, Wadsworth House, Cambridge, Mass.

Boston University Honors Dr. Overholser

For his outstanding service in psychiatry, Dr. Winfred Overholser, Superintendent of St. Elisabeths Hospital, Washington, was awarded the honorary degree of Doctor of Science by Boston University, on June 10. Dr. Overholser received his M.D. degree from Boston University in 1916. The citation prepared by the university in conferring the honorary degree said that it was being awarded because Dr. Overholser, by reason of his abilities, "has become a foremost psychiatrist of the present age."

Recognized as one of the nation's outstanding authorities in the treatment and handling of mental diseases, Dr. Overholser has been Superintendent of St. Elisabeths Hospital since 1937. Prior to that time he had filled many posts in the field of psychiatry and had taught in several schools. He joined the Massachusetts Department of Mental Diseases in 1917, and from 1934 to 1936 was commissioner of that department. In addition, he had served on the staff of several mental hospitals and is affiliated with many learned and professional societies and groups in psychiatry.

St. Elisabeths Hospital is one of the largest mental hospitals in the world, and is probably the best known mental institution in the country. The hospital was a bureau of the Department of the Interior from its founding in 1855 until last month when it severed its eighty-five-year association under the President's reorganization plan and was transferred to the Federal Security Agency.

Dr. Overholser was formerly professor of psychiatry at the Boston University School of Medicine and lecturer at the Boston University School of Law, and is now professor of psychiatry at George Washington University School of Medicine, Washington, D. C.

". . . And Now Alcoholism"

The need for a new approach to the problem of alcoholism was the keynote of a conference held in New York City on May 16 by the recently formed Research Council on Problems of Alcohol, an associated society of the American Association for the Advancement of Science, as a further step in the development of its scientific program. In a series of six round-table discussions, in which many aspects of the problem were taken up, speakers representing a variety of organizations and professions stressed the basic need for systematic and inclusive studies to throw light on the nature and causes of an evil concerning which little is known as yet in a scientific sense. Many questions were raised, the answers to which, it was felt, could be found only by persistent and painstaking scientific inquiry into the ramifications and complexities of this

obscure and baffling biological and social phenomena. A distinction was made between relatively harmless "social drinking" and the "disease of alcoholism," and emphasis was laid upon the necessity for an "objective scientific approach" as against the "futile reform movements of the past."

The organization of the new attack on alcoholism was characterized as "the mobilization of intelligence and brains" to deal with the problem in a planned way, in contrast to the hit-or-miss methods of prohibition and similar efforts with their exclusive emphasis on moral factors. Alcoholism, as one discussant put it, "is really a whole group of diseases, each of them calling for investigations not yet made." It was high time, another speaker said, to tackle this problem from the point of view and with the weapons of medical science, just as tuberculosis, cancer, syphilis, and other health problems have received scientific attention in recent years. An an indication of the neglect from which the problem of alcoholism has suffered, it was pointed out that, as compared with the many millions expended every year for, say, the treatment of tuberculosis, the annual expenditure for the treatment of alcoholic disease is well under a million dollars. And for the study of this disease, probably only between fifty and a hundred thousand dollars are available each year, compared with the million or more spent annually on cancer research. Practically no part of the huge liquor taxes collected annually in this country (some thirteen millions in New York State alone) is used for research in this field.

The seriousness of the problem is vividly set forth in an illuminating pamphlet, entitled ". . . . And Now Alcoholism," issued by the Research Council on Problems of Alcohol in an attempt to secure public support for its work. Copies may be secured from the Council at 60 East 42nd Street, New York City.

In a supplementary statement released after the conference, the nature of alcoholism is clarified, and the council's approach to the problem is described as follows:

Alcoholism—A Major Problem

"The Research Council on Problems of Alcohol will focus its attention during the years 1940 and 1941 on alcoholism and the alcoholic psychoses.

"Alcoholism manifests itself in characteristic mental and physical disorders. It is accompanied by social maladjustment in one or more of many realms of human activity. Alcohol has gained such a strong, habitual, and enduring hold on the alcoholic, that he finds himself unable, without assistance, to discontinue its use.

"Whether the disorder is caused by an abnormal reaction to alcohol, whether it is mainly the result of a maladjusted personality, how important relatively are physical and mental factors, the relation of nutrition to the disorder, the extent to which its beginnings may reach

back into childhood, and the rôle of heredity, are controversial questions on which additional research will provide more knowledge.

"An alcoholic should be regarded as a sick person, just as is one who is suffering from tuberculosis, cancer, heart disease, or any other serious chronic disorder. He should be looked upon as a person needing medical care instead of as one who is guilty of a moral or criminal offense.

"No one yet knows how many alcoholics there are in the United States. Only a comparatively few are treated in licensed sanitariums. For each of these patients, there are dozens in general hospitals, in unlicensed rest houses and other havens of refuge, and in their own homes. If the reader will recall the number of his friends and acquaintances who are alcoholics and will multiply that number by many thousands, he will then have only a minimum conception of the total number.

"Alcoholism causes a vast amount of inefficiency. It often leads to the premature discontinuance of useful work. It may shorten life. Not infrequently it is the cause of an alcoholic psychosis (a mental disorder resulting directly or indirectly from the use of alcohol). Over and above these considerations are the imponderables—the suffering of mothers, wives, husbands, and children. Children who live in the family of an alcoholic are frequently so crippled in the development of their personalities that they will have little chance for happiness and success in life.

"Treatment is sometimes mild and harmless, and sometimes strong and drastic. Many institutions bring the patient back to his physical optimum by good food, exercise, and occupational therapy; but he often finds it necessary to return to the institution again and again. Usually some fundamental difficulty, not understood, is left untouched.

"If medical science is to deal with alcoholism as it is dealing with the problems of tuberculosis, cancer, heart disease, syphilis, infantile paralysis, mental disease, and other major disorders, it must develop research in three fields: (1) fundamental causes, (2) methods of treatment, and (3) preventive measures.

"Cure and prevention are the goals—the latter being the more important. But a vast amount of research is necessary before either curative or preventive measures, adequate to the need, will be available for general use."

War Work of the Canadian Mental Hygiene Committee

"Conserving Mental Health During The War Period" is the theme of the May, 1940, *Mental Health Bulletin* of The National Committee for Mental Hygiene of Canada, the first in a new series published since the declaration of war in September, 1939. Quickly adapting its program to the exigencies of the European conflict, the Canadian Committee undertook a series of projects calculated to serve the Dominion's mental-hygiene needs on both the battle and the home front. To begin with, the committee canvassed the country's psychiatrists, psychiatric nurses, and other mental-hygiene personnel and secured biographical data for use in connection with medical mobilization plans of the Department of National Defense. There followed a review of the psychiatric history of the first World War

and of the Spanish Civil War, with a view to guiding Canadian policy for the prevention and treatment of war neuroses and other mental disabilities in the present war. Next came the organization of mental tests for the grouping of men in the military forces, the first time such tests have been introduced by the committee in the Canadian army. Experimental results have been such that the use of these tests is being extended to training camps in general. Finally, efforts are being made to establish measures looking to the strengthening of morale among the civilian population, by widespread educational work, the selection and training of counselors, and the development of hospital, clinic, and other mental-health services.

Mrs. William K. Vanderbilt

The death of Mrs. William K. Vanderbilt marks the passing of an outstanding figure in the American social and philanthropic scene. The newspaper accounts of her busy and useful life properly underline the wide range of her altruistic activities, as shown by the impressive list of her benefactions. Mrs. Vanderbilt was truly a "lady of charity." Among her numerous beneficiaries was The National Committee for Mental Hygiene, of which she was a generous supporter, giving liberally of her time and energies as well as her resources. She participated actively in its work as a member of its board of directors for several years.

We are especially in her debt for the handsome way she came to our aid during the formative years, when the National Committee was struggling to get on its feet and to establish the mental-hygiene movement, then in its infancy. Without the support we received from Mrs. Vanderbilt and the small band of far-visioned pioneers who gave such tangible expression of their faith in the cause of mental health, neither the National Committee nor the movement could have attained to the success achieved thus far in this challenging field of public health. We desire at this time publicly to record our appreciation of her splendid contributions and services.

State Society News

Kansas

The Kansas Mental Hygiene Society held its annual convention at Parsons, Kansas, April 19–20, under the chairmanship of Dr. Paul Murphy, president of the society, and with a distinguished roster of out-of-state and local speakers making up a program devoted to professional and popular topics. Several hundred members and guests of the society attended the various sessions of the conference, one of the most successful ever conducted in this state. The showing

of a number of motion pictures dealing with various phases of mental hygiene featured the meetings, and special attention was given to the organization of displays and exhibits concerned with the work of various mental-health facilities in Kansas. A new pamphlet, interpreting the aims of the society, was issued for the occasion. The society, which was organized in 1919, works mainly through its local county and city chapters, of which there are twelve functioning actively at the present time, and the emphasis is on the promotion of educational activities, aimed "not only at clearing up misconceptions concerning the movement itself, but also at giving the average person a more adequate insight into human motivation and behavior, in the hope that such information can contribute to happier living and so to better mental hygiene." The following officers were elected for the ensuing year: *President,* Dr. J. T. Naramore, Parsons; *Vice-President,* Miss Virginia Brents, Parsons; *Treasurer,* Mrs. Wilbert Mueller, Wichita; *Secretary,* Mrs. Melba Hoffman, Wichita; *Editor of the Bulletin,* Dr. W. H. Mikesell, Wichita.

Massachusetts

The Massachusetts Society for Mental Hygiene, in collaboration with the Massachusetts Conference of Social Work and a group of nine institutions for higher education, sponsored the Western Massachusetts Conference on Mental Hygiene in Education and Social Work held in Springfield on April 12 and 13, and attended by some 600 persons representing numerous schools and agencies in this part of the state. Some 75 speakers and discussants participated in the 12 section meetings, which were devoted to a two-part program dealing with the needs and interests of the social worker on the one hand and of the teacher on the other. Special features of the conference were a dinner meting, at which Dr. Frderick H. Allen, of Philadelphia, discussed "The Value of a Mental Hygiene Clinic to a Community," and a luncheon meeting addressed by Dr. Ira S. Wile, of New York, who spoke on "Mental Hygiene in the Field of Education."

The education program was organized around special topics of interest to school administrators, principals, and supervisors, with special attention to the needs of the elementary-school child, the secondary-school child, and the college student. The social-work program took up children's problems, delinquency, family relationships, relief, and social case-work, and the relations between religion and mental hygiene.

Minnesota

The newly formed Minnesota Mental Hygiene Society has just issued its first annual report. The main efforts have been directed

to completion of the organization process, to program study, and to the formation of various subcommittees to carry out the recommendations of the organizing committee. The first annual meeting was held on May 8, at which the constitution and by-laws of the society and the articles of incorporation were drawn up and adopted. The society now has a membership of nearly 200. The subcommittee on program recommended the following: (1) the establishment of a pavilion for psychotic children at the Hastings State Hospital; (2) the establishment of an observation-study home for children; (3) the extension of psychiatric services to children, with clinics in various parts of the state; and (4) the establishment of a psychiatric classification service for state training schools. A committee has also been appointed to consider recommendations growing out of a survey of state mental hospitals. A committee on public education proposed the following activities to be developed in the immediate future: (1) the establishment of a speakers' bureau; (2) the establishment of a directory and information service relative to the mental-hygiene and social-welfare facilities available in the state; (3) the establishment of an office and business center for the society; and (4) the development of mental-hygiene literature and exhibits.

Missouri

The Missouri Association for Mental Hygiene reports that there has been more demand for its educational services during the past year than at any other time since its organization in 1936. That the association has made every effort to meet this demand, in spite of a woefully inadequate budget, is evident from the enviable record of activities summarized in the April, 1940, issue of the *Mental Health Observer,* the association's quarterly journal. Particularly impressive is the widespread extension work undertaken through a network of county mental-hygiene societies which, besides holding regular meetings of their own, take advantage of other opportunities to bring the mental-health message to various local groups, engage in mental-hygiene surveys and studies, organize lecture courses and special discussion units, and otherwise to stimulate interest in and support of the state mental-hygiene program. During the current year eleven members of the association's speakers' bureau gave seventy lectures, attended by 11,000 persons. The executive committee has recently approved an experimental plan for the formation of local mental-hygiene committees in lieu of more formal mental-hygiene organizations in communities where new mental-hygiene groups are being considered. Especially encouraging to the association's executive officers, who are striving to improve and extend mental-health facilities in the state, is the good news that the board of managers of the

state eleemosynary institutions have decided to place psychiatric social workers in the mental hospitals of Missouri. The Fourth Annual Conference of the association will be held at the new Bliss Psychopathic Institute in St. Louis on October 12, 1940.

New York

The thirtieth Annual Meeting of the New York State Committee on Mental Hygiene was held on June 14, at 105 East 22nd Street, New York City. Dr. William L. Russell, chairman of the committee for more than five years, presided.

Dr. William J. Tiffany gave a brief account of developments in the State Department of Mental Hygiene. Of special interest to the committee were plans for extending the family care and parole programs of the department. The committee has actively supported this movement, believing that it will materially reduce the cost of care, and also provide a happier and more normal way of living for many patients who no longer require institutional treatment.

Dr. George S. Stevenson reported on current projects of The National Committee for Mental Hygiene, including the experimental work in Delaware and the professional education program in Texas, school and personnel studies, and medical residencies in state hospitals.

Dr. Louis Casamajor, chairman of the subcommittee on legislation, reported that legislation this year was of less importance than usual, but that the committee had helped to defeat several very undesirable bills.

Dr. Casamajor, who is also chairman of the subcommittee on mental hygiene in general medicine, reported on a study now in progress of the contacts mental patients have had with general practitioners. Questionnaires have been sent to state hospitals asking for data on 1,000 newly admitted patients. Of the replies so far received, 500 have been tabulated. Data indicate that many mental patients have been seen within a short time of commitment by general practitioners, who failed to notice the mental danger signals. The most striking information so far obtained is that of the 500 newly admitted patients, only 5 per cent had ever consulted a psychiatrist up to the time of the breakdown that led to commitment.[1]

Miss Ridenour described new reading material and the distribution of pamphlets. The committee have prepared and printed a pamphlet on the care of mental defectives living at home, a "quiz" on state care of the mentally ill, and a short outline for study of community mental-hygiene needs for women's clubs. A study outline for the staffs of children's institutions printed last year was reprinted to

[1] The study is to be published when completed.

answer continuing demand. Six pamphlets from other sources were reproduced for distribution.

Miss Ecob reported on other staff activities. The committee has continued its educational program with clergymen, teachers, nurses, and social workers, mainly through the professional organizations of these groups. The fourteen county mental-hygiene committees affiliated with the state committee have almost all accomplished some useful project during the year. Their activities are mainly educational. None have had funds from outside the county, yet nearly all can meet expenses from profits on lecture courses. The Oneida County Mental Hygiene Committee, active since 1927, closed the year with nearly $600 in the bank. A new committee was organized in Nassau County and plans are nearly complete for committees in two other counties.

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